

0-03589

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10395  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>ELSIE</u> MIDDLE <u>ABRAMSON</u> LAST <u>ABRAMSON</u> <u>Elsie</u> <u>Abramson</u>		2a. DATE OF DEATH MONTH <u>04</u> DAY <u>09</u> YEAR <u>86</u>		2b. HOUR <u>13</u> <u>55</u> P.M.	
3. SEX <u>F</u> FEMALE		4. RACE <u>W</u> WHITE		5. DATE OF BIRTH MONTH <u>12</u> DAY <u>23</u> YEAR <u>06</u>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS. IF UNDER 1 YEAR: MONTHS <u>  </u> DAYS <u>  </u> IF UNDER 24 HRS: HOURS <u>  </u> MIN. <u>  </u>	
10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai Hospital of Baltimore</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		13a. STREET ADDRESS / ZIP CODE <u>6216 NORVO RD. #21207</u>	
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>BALTO.</u>		13c. CITY OR TOWN <u>BALTIMORE</u>	
14. FATHER'S NAME FIRST <u>MORRIS</u> MIDDLE <u>  </u> LAST <u>BLOOM</u>		15. MOTHER'S MAIDEN NAME FIRST <u>LENA</u> MIDDLE <u>  </u> LAST <u>COHEN</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO. <u>176-34-8840</u>		17. INFORMANT <u>JOEL ABRAMSON</u>		17. ADDRESS <u>759 SHORE DR. JOPPATOWNE, MD 21085</u>	

18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metabolic acidosis (A-E) cardiac</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pulmonary metastases

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <u>  </u> A.M. MONTH <u>  </u> DAY <u>  </u> YEAR <u>19</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <u>  </u> CITY OR TOWN <u>  </u> COUNTY <u>  </u> STATE <u>  </u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/9</u> 19 <u>86</u> to <u>4/9</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/9</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Frederick J. Von Ben</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/9/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FREDERICK J. VON BEN</u>		22e. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>APR. 11, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MIKRO KODESH-BETH ISRAEL</u>		23d. LOCATION CITY OR TOWN <u>BALTIMORE</u> COUNTY <u>  </u> STATE <u>MARYLAND</u>	
24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON &amp; BROS., INC.</u> ADDRESS <u>6010 REISTERSTOWN RD. BALTO. MD 21215</u>				25. DATE RECEIVED BY REGISTRAR <u>APR 15 1986</u> REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodriguez</u>			

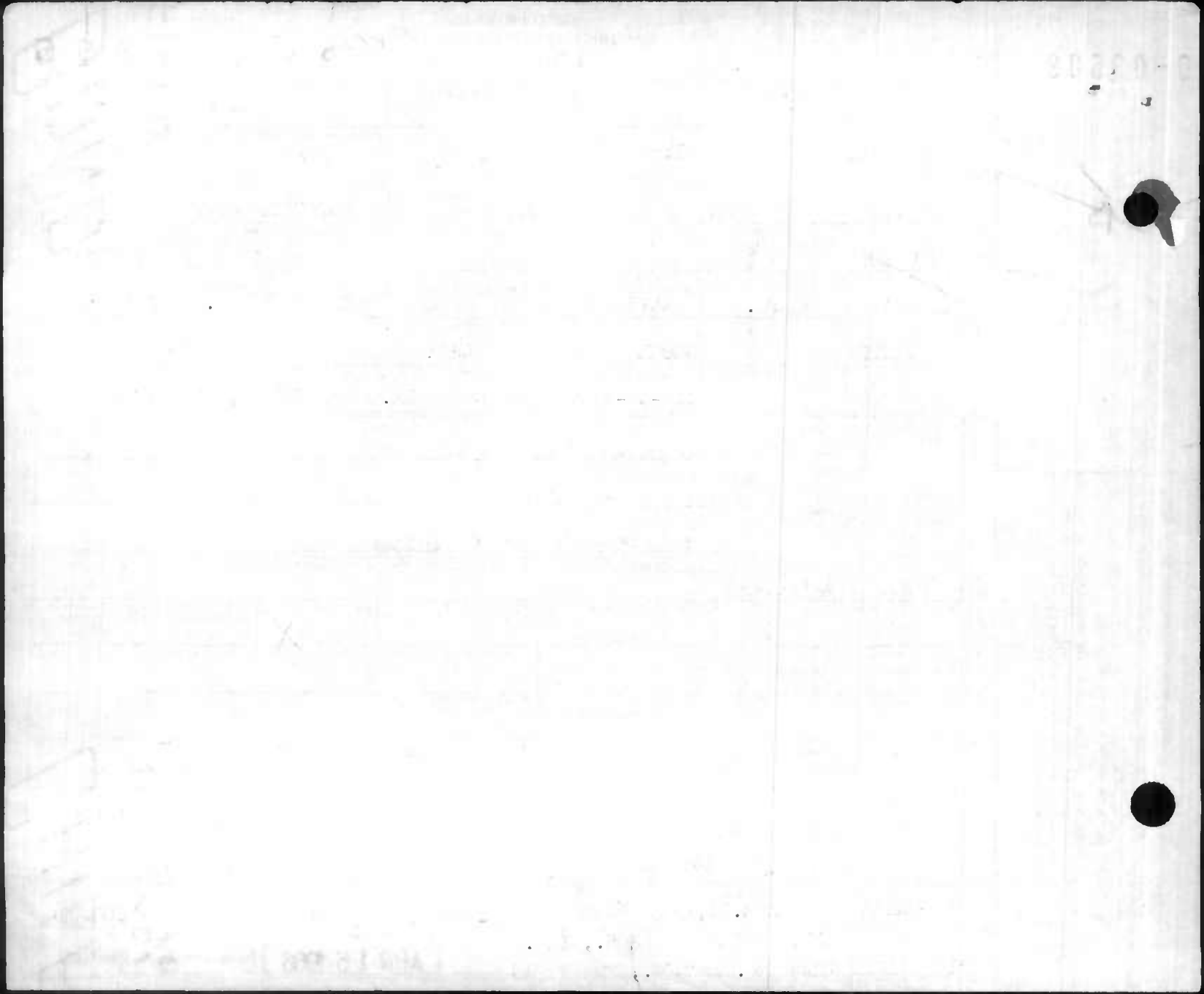
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



00-02891

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10396

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
		HARRY Franklin ADAMS					DATE MATED <input type="checkbox"/>		4	4	19 86	M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH		DAY	YEAR	2d. HOUR
Male	White	1/29/1911	75 YRS.	MONTHS	DAYS	4 4 19 86						9:29 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA				Baltimore City		MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		University Hospital (STU)				Ret. Trainman/B & O R.R.						
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN		13c. STREET ADDRESS		21226				
Maryland				Baltimore		4105 Morrison Court,						
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
Norman Eugene Adams				Mary Evelyn Burke								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		21784 Dr. Sykesville, Md.				
no				705-05-5098		Nowlin S. Phillips		1300 Hillcrest				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforating gunshot wound of head (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to the immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <u>4-3</u> MONTH <u>4</u> DAY <u>3</u> YEAR <u>1986</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
				1:30 P.M.		Self-inflicted.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 4105 Morrison Ct., Balto.		CITY OR TOWN		COUNTY	STATE	
											MD	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)				Ann M. Dixon, M.D.				DATE SIGNED 4-4-86				
				ADDRESS 111 Penn St., Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN				
Burial				4/7/1986		Mt. Olivet Cemetery		Frederick, Frederick, Md.				
24. FUNERAL DIRECTOR NAME				237 E. Patapsco Ave., ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
McCully Funeral Homes				Balto., Md. 21225				APR 8 1986		John Davidson		

07/84  
25M

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DHMH - 17  
(VR A15 ME (5))





00-048650

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10397			
1- FOR STATE REGISTRAR										7a. DATE KNOWN OF DEATH		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN DAVID ADAMS										ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4-20-86		M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 9 32		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 53 YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		7c. DATE PRONOUNCED DEAD 4-20-86			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 910 Walnut Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cab Driver		12b. KIND OF BUSINESS OR INDUSTRY Cab			
13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 910 Walnut Ave. 21229			
14. FATHER'S NAME FIRST MIDDLE LAST John Adams						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Mae							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 255-46-0378		17. INFORMANT ADDRESS Alpha Thomas 2824 W. Lanvale St. 21216							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Margaret Anne Yule</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 4-21-86					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-28-86		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME Marshall W. Jones, Jr.				ADDRESS 4101 Edmondson Ave		25a. DATE REC'D. BY REGISTRAR APR 25 1986		25b. REGISTRAR'S SIGNATURE					

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

1500-0000

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2312

[5]

Figure 10.10

00-05364

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 10398

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT H. ADAMS			2a DATE OF DEATH MONTH DAY YEAR APRIL 28, 1986		2b HOUR 8:46AM
3 SEX M	4 RACE B	5 DATE OF BIRTH MONTH DAY YEAR 7 27 21		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN) VIRGINIA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE		12b KIND OF BUSINESS OR INDUSTRY
13a STATE MARYLAND		13b COUNTY	13c CITY OR TOWN BALTIMORE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JOHNNY ADAMS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 247241158		17 INFORMANT ADDRESS ROBIN ADAMS 143 N.MILTON AVE.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ACUTE AND CHRONIC RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF <u>HYPERTENSION, CORONARY</u> (c) <u>ARTERY DISEASE, CEREBROVASCULAR ACCIDENT</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CONGESTIVE HEART FAILURE, PERIPHERAL VASCULAR DISEASE</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from <u>MARCH 20</u> , 19 <u>86</u> , to <u>APRIL 28</u> , 19 <u>86</u> , that (1) <u>we</u> saw the deceased alive on <u>APRIL 20</u> , 19 <u>86</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> did <u>not</u> view the body after death.					
22b SIGNATURE <u>Muhees Adeola M.D.</u>		DEGREE M.D.		22c DATE SIGNED 4/28/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MUHEES ADEOLA M.D.		22e ADDRESS CHURCH HOSPITAL CORPORATION 100 NORTH BROADWAY BALTO., MD. 21231			
23a BURIAL, CREMATION, REMOVAL BURIAL		23b DATE 5-2-86		23c NAME OF CEMETERY OR CREMATORY EASTVIEW	
23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24 FUNERAL DIRECTOR NAME ADDRESS WM.C.MARCH F/H INC. 1101 E.NORTH AVE.		25a DATE REC'D. BY REGISTRAR MAY 1 1986			
		25b REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.)

1. NAME (Last, First, Middle Initial)

2. DATE OF BIRTH (Month/Day/Year)

3. SEX (Male/Female)

4. RACE (Caucasian/Hispanic/Black/Asian/Other)

5. ETHNICITY (Caucasian/Hispanic/Black/Asian/Other)

6. OCCUPATION (Employer/Unemployed/Retired)

7. EDUCATION (High School/College/Postgraduate)

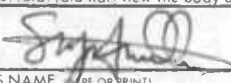
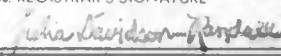
8. RELIGION (Catholic/Protestant/Jewish/Muslim/Other)

9. MARITAL STATUS (Single/Married/Divorced/Widowed)

10. NUMBER OF CHILDREN (0/1/2/3/4/5/6/7/8/9/10/11/12/13/14/15/16/17/18/19/20/21/22/23/24/25/26/27/28/29/30/31/32/33/34/35/36/37/38/39/40/41/42/43/44/45/46/47/48/49/50/51/52/53/54/55/56/57/58/59/60/61/62/63/64/65/66/67/68/69/70/71/72/73/74/75/76/77/78/79/80/81/82/83/84/85/86/87/88/89/90/91/92/93/94/95/96/97/98/99/100/101/102/103/104/105/106/107/108/109/110/111/112/113/114/115/116/117/118/119/120/121/122/123/124/125/126/127/128/129/130/131/132/133/134/135/136/137/138/139/140/141/142/143/144/145/146/147/148/149/150/151/152/153/154/155/156/157/158/159/160/161/162/163/164/165/166/167/168/169/170/171/172/173/174/175/176/177/178/179/180/181/182/183/184/185/186/187/188/189/190/191/192/193/194/195/196/197/198/199/200/201/202/203/204/205/206/207/208/209/210/211/212/213/214/215/216/217/218/219/220/221/222/223/224/225/226/227/228/229/230/231/232/233/234/235/236/237/238/239/240/241/242/243/244/245/246/247/248/249/250/251/252/253/254/255/256/257/258/259/260/261/262/263/264/265/266/267/268/269/270/271/272/273/274/275/276/277/278/279/280/281/282/283/284/285/286/287/288/289/290/291/292/293/294/295/296/297/298/299/300/301/302/303/304/305/306/307/308/309/310/311/312/313/314/315/316/317/318/319/320/321/322/323/324/325/326/327/328/329/330/331/332/333/334/335/336/337/338/339/340/341/342/343/344/345/346/347/348/349/350/351/352/353/354/355/356/357/358/359/360/361/362/363/364/365/366/367/368/369/370/371/372/373/374/375/376/377/378/379/380/381/382/383/384/385/386/387/388/389/390/391/392/393/394/395/396/397/398/399/400/401/402/403/404/405/406/407/408/409/410/411/412/413/414/415/416/417/418/419/420/421/422/423/424/425/426/427/428/429/430/431/432/433/434/435/436/437/438/439/440/441/442/443/444/445/446/447/448/449/450/451/452/453/454/455/456/457/458/459/460/461/462/463/464/465/466/467/468/469/470/471/472/473/474/475/476/477/478/479/480/481/482/483/484/485/486/487/488/489/490/491/492/493/494/495/496/497/498/499/500/501/502/503/504/505/506/507/508/509/510/511/512/513/514/515/516/517/518/519/520/521/522/523/524/525/526/527/528/529/530/531/532/533/534/535/536/537/538/539/540/541/542/543/544/545/546/547/548/549/550/551/552/553/554/555/556/557/558/559/560/561/562/563/564/565/566/567/568/569/570/571/572/573/574/575/576/577/578/579/580/581/582/583/584/585/586/587/588/589/590/591/592/593/594/595/596/597/598/599/600/601/602/603/604/605/606/607/608/609/610/611/612/613/614/615/616/617/618/619/620/621/622/623/624/625/626/627/628/629/630/631/632/633/634/635/636/637/638/639/640/641/642/643/644/645/646/647/648/649/650/651/652/653/654/655/656/657/658/659/660/661/662/663/664/665/666/667/668/669/670/671/672/673/674/675/676/677/678/679/680/681/682/683/684/685/686/687/688/689/690/691/692/693/694/695/696/697/698/699/700/701/702/703/704/705/706/707/708/709/710/711/712/713/714/715/716/717/718/719/720/721/722/723/724/725/726/727/728/729/730/731/732/733/734/735/736/737/738/739/740/741/742/743/744/745/746/747/748/749/750/751/752/753/754/755/756/757/758/759/760/761/762/763/764/765/766/767/768/769/770/771/772/773/774/775/776/777/778/779/780/781/782/783/784/785/786/787/788/789/790/791/792/793/794/795/796/797/798/799/800/801/802/803/804/805/806/807/808/809/810/811/812/813/814/815/816/817/818/819/820/821/822/823/824/825/826/827/828/829/830/831/832/833/834/835/836/837/838/839/840/841/842/843/844/845/846/847/848/849/850/851/852/853/854/855/856/857/858/859/860/861/862/863/864/865/866/867/868/869/870/871/872/873/874/875/876/877/878/879/880/881/882/883/884/885/886/887/888/889/890/891/892/893/894/895/896/897/898/899/900/901/902/903/904/905/906/907/908/909/910/911/912/913/914/915/916/917/918/919/920/921/922/923/924/925/926/927/928/929/930/931/932/933/934/935/936/937/938/939/940/941/942/943/944/945/946/947/948/949/950/951/952/953/954/955/956/957/958/959/960/961/962/963/964/965/966/967/968/969/970/971/972/973/974/975/976/977/978/979/980/981/982/983/984/985/986/987/988/989/990/991/992/993/994/995/996/997/998/999/1000/1001/1002/1003/1004/1005/1006/1007/1008/1009/1010/1011/1012/1013/1014/1015/1016/1017/1018/1019/1020/1021/1022/1023/1024/1025/1026/1027/1028/1029/1030/1031/1032/1033/1034/1035/1036/1037/1038/1039/1040/1041/1042/1043/1044/1045/1046/1047/1048/1049/1050/1051/1052/1053/1054/1055/1056/1057/1058/1059/1060/1061/1062/1063/1064/1065/1066/1067/1068/1069/1070/1071/1072/1073/1074/1075/1076/1077/1078/1079/1080/1081/1082/1083/1084/1085/1086/1087/1088/1089/1090/1091/1092/1093/1094/1095/1096/1097/1098/1099/1100/1101/1102/1103/1104/1105/1106/1107/1108/1109/1110/1111/1112/1113/1114/1115/1116/1117/1118/1119/1120/1121/1122/1123/1124/1125/1126/1127/1128/1129/1130/1131/1132/1133/1134/1135/1136/1137/1138/1139/1140/1141/1142/1143/1144/1145/1146/1147/1148/1149/1150/1151/1152/1153/1154/1155/1156/1157/1158/1159/1160/1161/1162/1163/1164/1165/1166/1167/1168/1169/1170/1171/1172/1173/1174/1175/1176/1177/1178/1179/1180/1181/1182/1183/1184/1185/1186/1187/1188/1189/1190/1191/1192/1193/1194/1195/1196/1197/1198/1199/1200/1201/1202/1203/1204/1205/1206/1207/1208/1209/1210/1211/1212/1213/1214/1215/1216/1217/1218/1219/1220/1221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0-04796

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10399  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BENTE N ADLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 20, 1986</b>		2b. HOUR <b>01:15 am</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 14, 1945</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DENMARK</b>		7c. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>WHITE HALL</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>EVALD JENSEN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTHER NORGAARD</b>		13e. STREET ADDRESS / ZIP CODE <b>4616 HARFORD CREAMERY RD. 21161</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-58-4849</b>		17 INFORMANT <b>JOEL ADLER</b> ADDRESS <b>4616 HARFORD CREAMERY RD. WHITE HALL, MD 21161</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Recurrent Ovarian Carcinoma</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0-5 minutes</b> <b>times 7-10 days</b> <b>times 10 years</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>April 16</b> , 19 <b>86</b> , to <b>April 20</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>April 19th</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 		DEGREE		22c. DATE SIGNED <b>4/20/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen A Miller</b>		22e. ADDRESS <b>600 N WOLFEST BALTIMORE, MARYLAND</b> <b>THE JOHNS HOPKINS HOSPITAL 21205</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APR. 21, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>REISTERSTOWN BALTO. MD</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 25 1986</b>				
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		25b. REGISTRAR'S SIGNATURE 				
ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS 100 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

WATER



00-03963

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

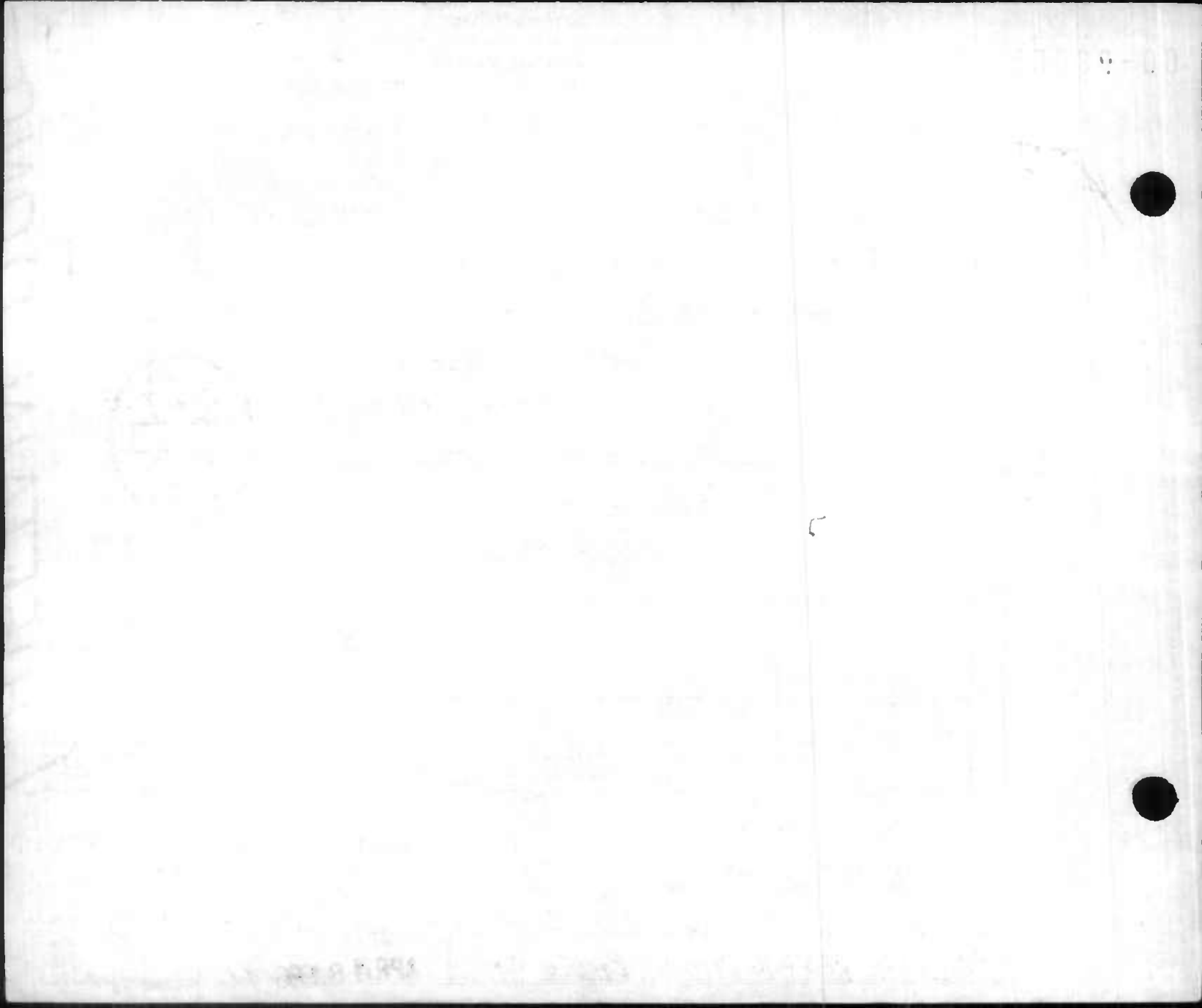
DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

10400

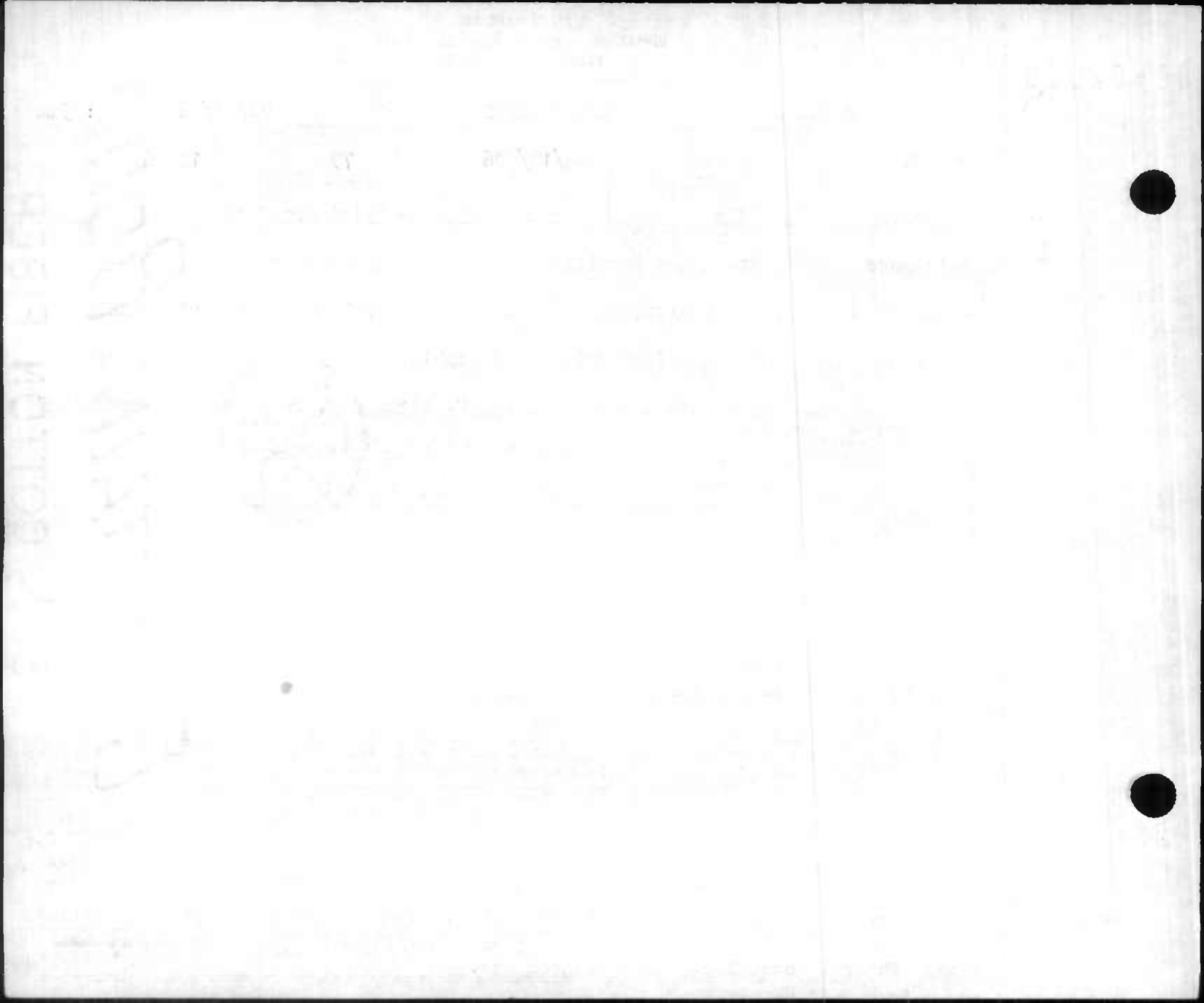
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PHILLIP L. ALCOON				2a. DATE OF DEATH MONTH DAY YEAR 4 13 86				2b. HOUR 10 <sup>10</sup> PM M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 26 42		6. AGE (IN YEARS LAST BIRTHDAY) 43		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD.		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
12. CITY OR TOWN OF DEATH BALTIMORE CITY		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSPITAL				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE COUNTY MARYLAND BALTO. CITY		17. CITY OR TOWN BALTO. CITY		18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. STREET ADDRESS / ZIP CODE 511 N. FULTON AVENUE 21223			
20. FATHER'S NAME FIRST MIDDLE LAST JAMES ALCOON		21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA HARGROVE		22. SOCIAL SECURITY NO. 219-38-5834					
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		24. SOCIAL SECURITY NO. 219-38-5834		25. INFORMANT ADDRESS EMMA WATKINS 511 FULTON AVE					
26. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) HYPERKALEMIA, METABOLIC ACIDOSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HRS 8 HRS UNKNOWN									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a AIDS, END STAGE RENAL DISEASE									
27a. DATE OF OPERATION		27b. CONDITION FOR WHICH OPERATION WAS PERFORMED				28a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
30a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		30b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		30c. LOCATION STREET CITY OR TOWN COUNTY STATE					
31. I certify that (1) (this hospital) attended the deceased from 4/13, 1986, to 4/13, 1986, that (1) (we) last saw the deceased alive on 4/13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
32a. SIGNATURE Stephen R. Yeagle M.D.				32b. DEGREE M.D.		32c. DATE SIGNED 4/13/86		32d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
33a. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN R. YEAGLE				33b. ADDRESS GREEN & LOMBARD STS., BALTIMORE, MD 21201 DEPT. MEDICINE, UNIVERSITY OF MARYLAND HOSP.					
34a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		34b. DATE 4-19-86		34c. NAME OF CEMETERY OR CREMATORY MT. ZION Cem.		34d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND		34e. DATE REC'D. BY REGISTRAR APR 18 1986	
35. FUNERAL DIRECTOR NAME BROWN/THOMPSON F.H. 1913 W. BALTO. ST.				35b. ADDRESS BALTO. ST.		35c. DATE REC'D. BY REGISTRAR APR 18 1986		35d. REGISTRAR'S SIGNATURE John F. ...	









00-04514

 1- STATE REGISTRAR  
 Items 13a-13e.  
 5-6-86 Perphone  
 A.L.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

86 10402

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GREGORY LEROY ALI Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 10 86</b>			2b. HOUR <b>4.33am</b>	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 10 86</b>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS. - - 2 30</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>MD</b>		13b. COUNTY <b>MA.A.</b>		13c. CITY OR TOWN <b>Glenburnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gregory Leroy Ali</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rowena Winona Wilkerson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>PREMATURITY</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)							
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>NO</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>NO</b>			
21d. INJURY OCCURRED <b>NO</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>NO</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/10 86</b> to <b>4/10 86</b> that (I) (we) last saw the deceased alive on <b>4/10 86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John A. Hackett</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/10/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HACKETT</b>				22e. ADDRESS <b>South Baltimore HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>4-17-86</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Anatomy Board Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 24 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rodden</b>	

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove portions 1 and 2 and return them to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition.  
 IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-04214

1000 1000 1000

1000 1000 1000

1000 1000

1000 1000 1000

1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610403

REG. NO.

1- FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		APRIL 27, 1986		11:25pm	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR	
male		black		9 9 1941	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
S. C.		U S A		BALTIMORE CITY OR COUNTY OF DEATH	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		Unemployed	
13a STATE		13b COUNTY		13c CITY OR TOWN	
Md				Baltimore	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Samuel Lee Allen		Hattie Williams		No	
16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gram negative sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Liver failure</u>	
220-36-9921		Hattie Allen 3126 Belmont Avenue		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours 24 hours 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cirrhosis, Portal HTN</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
				P.M. 19	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from <u>4/25/86</u> 19 <u>86</u> , to <u>4/27/86</u> 19 <u>86</u> that (1) (we) last saw the deceased alive on <u>4/27/86</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
Edward Kasper mo				4/27/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f DATE REC'D. BY REGISTRAR	
EDWARD KASPER		600 N WOLFE ST BAL TO, MD 21205		John Davidson	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		5/2/86		Arbutus Memorial Park	
23d LOCATION		23e NAME OF CEMETERY OR CREMATORY		23f LOCATION	
Arbutus		Arbutus		COUNTY STATE Md	
24 FUNERAL DIRECTOR NAME ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
March Funeral Home West 4300 Wabash Avenue		APR 29 1986		John Davidson	

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

0-12003



00-02915

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

10404

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HINDA <del>XXXXXX</del> ALLIKER			2a. DATE OF DEATH MONTH DAY YEAR 04-05-86			2b. HOUR 2 1/2 M			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 02-09-1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE AGED HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE (21209) 2905 FALLSTAFF RD., APT. 28	
14. FATHER'S NAME FIRST MIDDLE LAST YECHIEL SUTTLEMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA HIMELFARB			ADDRESS APT. 28 (21209)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-74-4705		17. INFORMANT ADDRESS MRS. MILDRED R. ROSKES 2905 FALLSTAFF RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ISCHEMIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 YRS.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Left lower lobe pneumonia</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1, OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>07-31</u> 19 <u>84</u> , to <u>04-05</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>04-05</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>B-ZAW-WIN</u>			DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 04-05-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B-ZAW-WIN			22e. ADDRESS LEVINDALE GERIATRIC COR BALTO 21215						
23a. BURIAL, CREMATION, REMOVAL SPECIES BURIAL			23b. DATE 4/7/86		23c. NAME OF CEMETERY OR CREMATORY FORBAND CEM		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215					25a. DATE REC'D. BY REGISTRAR APR 08 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Dearden</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Properly filled out, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP





00-05416

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

10405

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			26. DATE KNOWN OF DEATH			27. DATE OF ESTI- MATED			28. HOUR		
LARRY			ALSTON			4 30 19 86			4 30 19 86			8:33 PM		
2. SEX			3. RACE			4. DATE OF BIRTH			5. AGE (IN YEARS)			6. IF UNDER 1 YR.		
M.			B.			10 14 46			39 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. NEVER MARRIED			10. DIVORCED		
Balto... Md.			U.S.A.			WIDOWED			NEVER MARRIED			DIVORCED		
11. CITY OR TOWN OF DEATH			12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			14. KIND OF BUSINESS OR INDUSTRY			15. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore			Key Medical Center			Crane Operator			Steel			Baltimore City MD		
16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			17. STATE			18. COUNTY			19. CITY OR TOWN			20. INSIDE CITY LIMITS?		
Md.			Balto			Turners			YES NO			21. STREET ADDRESS		
												655 N. Avondale Rd.		
22. FATHER'S NAME			23. MOTHER'S MAIDEN NAME			24. SOCIAL SECURITY NO.			25. INFORMANT			26. ADDRESS		
Thomas Alston			Shirley King			215 46 8199			Mrs. Lessie Alston			655 N. Avondale		
27. WAS DECEASED EVER IN U.S. ARMED FORCES?			28. SOCIAL SECURITY NO.			29. INFORMANT			30. ADDRESS			31. DATE		
Yes			69-71			215 46 8199			Mrs. Lessie Alston			655 N. Avondale		
32. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Ethanolism</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>														
(c) <u></u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
33. DATE OF OPERATION			34. CONDITION FOR WHICH OPERATION WAS PERFORMED?			35. AUTOPSY?			36. YES			37. NO		
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION			21e. PLACE OF INJURY		
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION			21e. PLACE OF INJURY		
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION			21e. PLACE OF INJURY		
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION			21e. PLACE OF INJURY		
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE			TITLE			DATE SIGNED			38. MEDICAL EXAMINER			39. DATE		
Dennis F. Smyth, M.D.			Assistant			5-1-86			111 Penn St., Balto., MD			21201		
40. BURIAL, CREMATION, REMOVAL (SPECIFY)			41. DATE			42. NAME OF CEMETERY OR CREMATORY			43. LOCATION			44. STATE		
Burial			5/6/86			Garrison Forest			Owings Mill, Md.			MD		
45. FUNERAL DIRECTOR			46. DATE REC'D. BY REGISTRAR			47. REGISTRAR'S SIGNATURE			48. DATE			49. REGISTRAR'S SIGNATURE		
Jas. A. Morton & Sons 1701 Laurens			MAY 2 1986			John A. Morton			MAY 2 1986			John A. Morton		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 18. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82



00-05674

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10406

REG. NO.

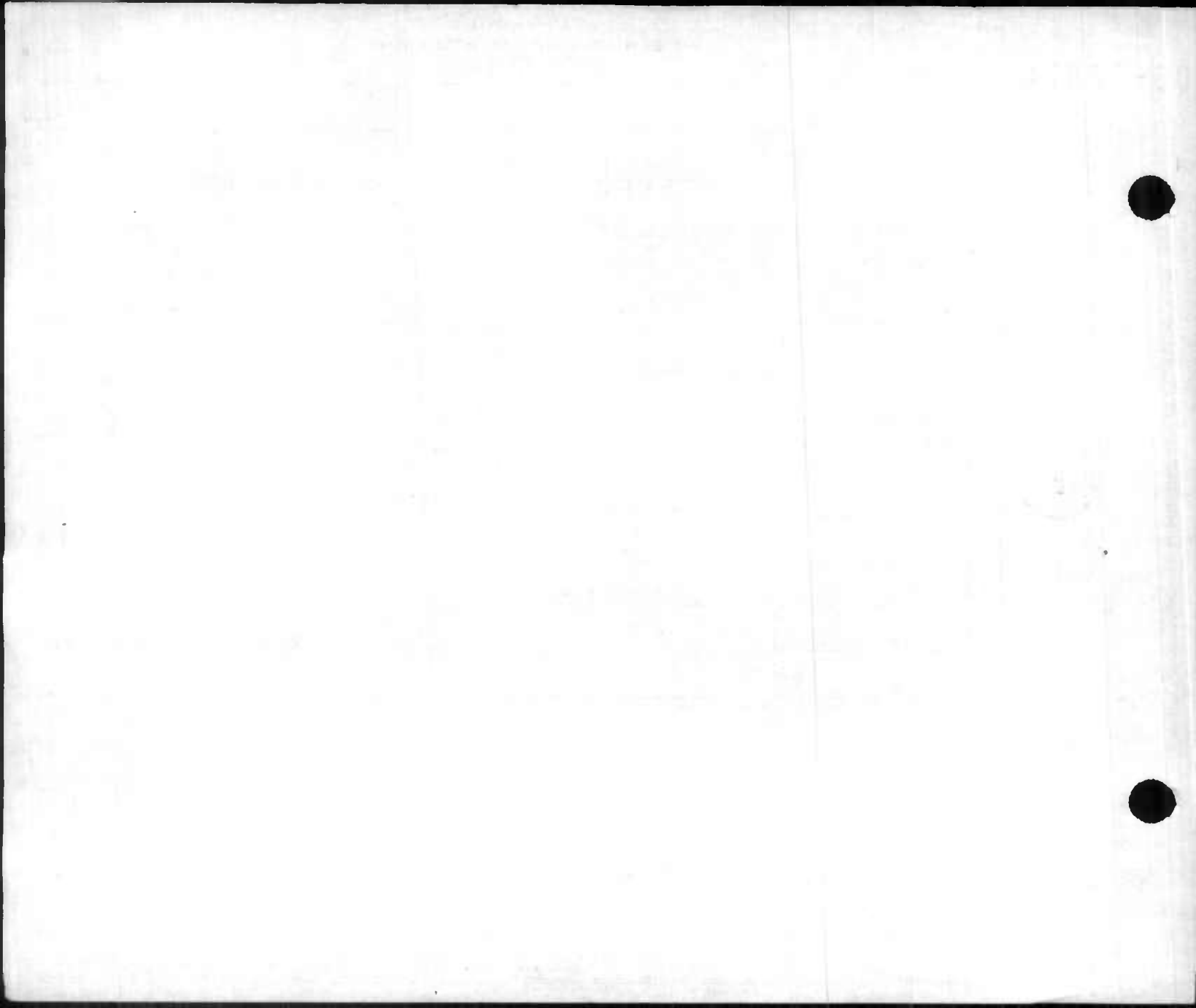
1 DECEASED NAME (TYPE OR PRINT) <b>Louise</b>			2a DATE OF DEATH MONTH DAY YEAR <b>April 25, 1986</b>			2b HOUR <b>1:50P M</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>4 26 07</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Md.</b>		13b COUNTY <b>Balto.</b>		13c CITY OR TOWN <b>Balto.</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>301 McMechen St. 21217</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Raphael</b> <b>Colangelo</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Loretta</b> <b>Schiavonne</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>214-20-3637</b>		17 INFORMANT <b>Ms. Bonnie Hoback</b>		1612 ADDRESS <b>Bolton St.</b>		16b. ADDRESS <b>Balto., Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Multi-system organ failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Strangulated ventral hernia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>XXXXXXXXXXXX</b>									
19a DATE OF OPERATION <b>April 8, 1986</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Strangulated ventral hernia with gangrenous bowel</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>P.M.</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (x) (this hospital) attended the deceased from <b>April 1</b> , 19 <b>86</b> , to <b>April 25</b> , 19 <b>86</b> that <b>X</b> (we) last saw the deceased alive on <b>April 25</b> , 19 <b>86</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(X we)</b> (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/25/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. F. [Signature]</b>		22e. ADDRESS <b>Md. General Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>4-27-86</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 05 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-03962

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

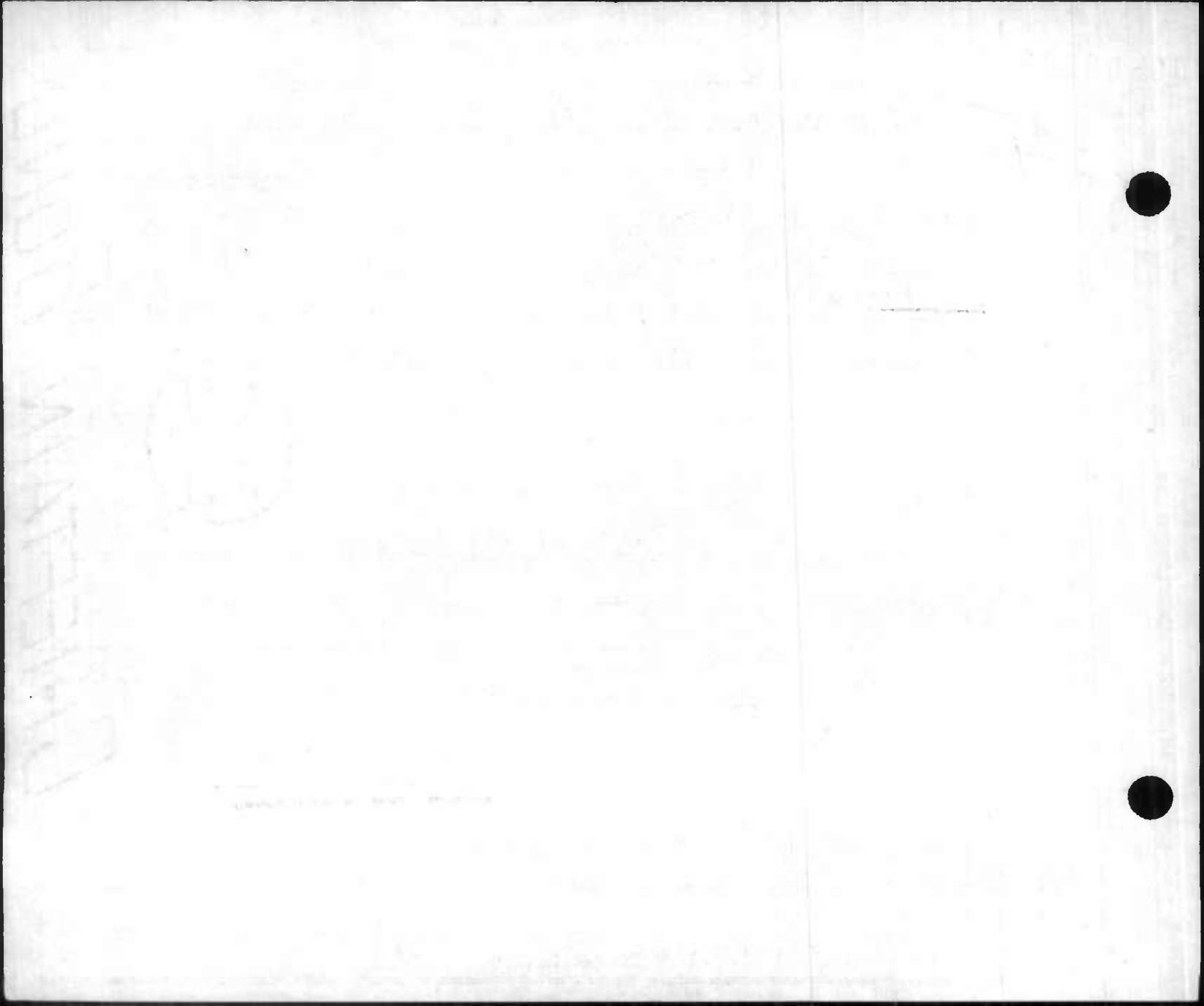
86 10407

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST BLANCHAM AMOS JR.		4/16/86		4:43 A.M.	
3. SEX M	4. RACE BLK	5. DATE OF BIRTH MONTH DAY YEAR 10 10 25	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD		
10. CITY OR TOWN OF DEATH BALTIMORE MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) HEIMSS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroad	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. CITY OR TOWN BALTIMORE	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 419 E. LORRAINE AVE BALTIMORE MD 21218		
14. FATHER'S NAME FIRST MIDDLE LAST BLANCHAM AMOS SR.	15. MOTHER'S MAIDEN NAME FIRST MIDDLE CONNELLY L. LIDD		16. SOCIAL SECURITY NO. n/a		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	17. INFORMANT ADDRESS Willie Mae Robinson 419 E. Lorraine Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 8809 IMMEDIATE CAUSE (a) Full Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN ? Blood Clot to Lungs DUE TO, OR AS A CONSEQUENCE OF (c) PT Had injury to spine cord Diagnosed 4/5/86 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 minutes		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 10 P.M. 4-5- 1986			
21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) PT fell down right of stairs			
22a. I certify that (1) (this hospital) attended the deceased from 4/15 to 4/16, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did not) view the body after death.		22b. SIGNATURE Soul J. [Signature]			
22c. DATE SIGNED 4/16/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]			
22e. ADDRESS		22f. DEGREE CERTIFICATION APPROVED BY MEDICAL EXAMINER ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-21-86		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		24. FUNERAL DIRECTOR WM. C. MARCH F/H INC. 1101 E. NORTH AVE.			
25a. DATE RECD BY REGISTRAR APR 18 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



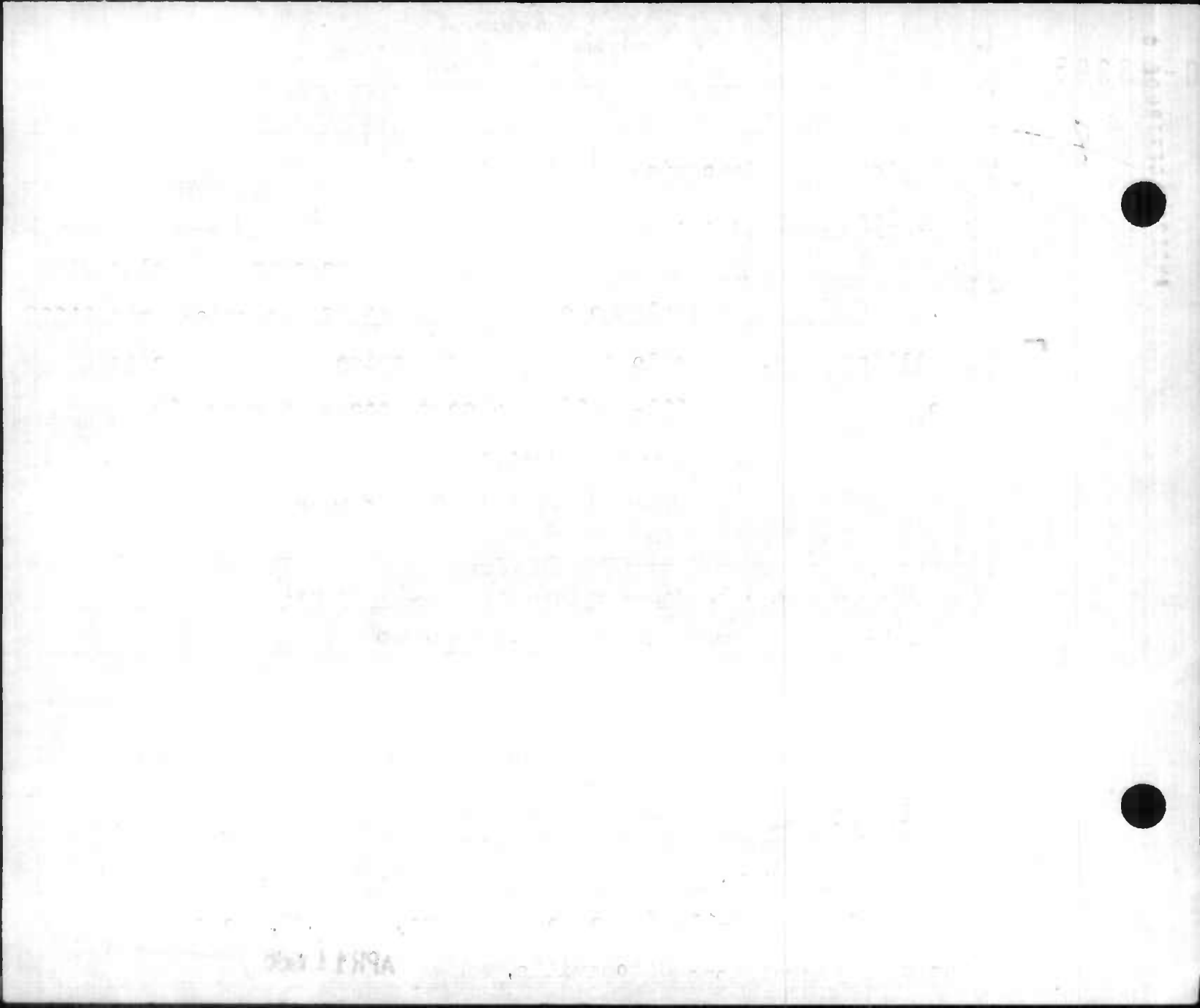
0-3395

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10408

REG. NO.

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	P M
GERTRUDE		G		ANDERS	APRIL 8, 1986					1:47	P
SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	Caucasian		4 30 06		79 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	U.S.A.				BALTIMORE CITY		MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
BALTIMORE	JOHNS HOPKINS HOSPITAL		Secretary		Balto City						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5532 Frederick Road 21228			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
William C. Galloway		Catherine Thomas		No		212-05-2689		Walcott Anders		Same as #13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Peripheral Vasc Disease, Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 mins</u> <u>5 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Old age, Renal Insufficiency, Dementia, inability to Eat</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
3/17		Severe peripheral vascular Disease		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from		3/9 19 86, to 4/8 19 86, that (I) (we) lost		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
saw the deceased alive on 4/8 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		above, (I) (we) (did) (did not) view the body after death.		G. Steinberg				4/8/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS					
G. Steinberg		Johns Hopkins Hospital, Balt Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		04-12-86		Loudon Park Cem.		Baltimore Md.					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
MacNabb Funeral Home		Catonsville, Md		APR 11 1986		John Davidson					





00-05332

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMM - 17  
(VR A15 ME (1))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10409

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Dolores Lorraine Anderson		Female		Blk.	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
9 6 39		36 YRS.		Wash., D.C.	
8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. HOUR	
NEVER MARRIED		Baltimore City, MD		11:45 P M	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY	
4101 Bonner Rd.		Liaison Clerk			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.				Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
William H. Anderson		Susie Russell		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
578-52-6598		Paulette Dye		PART I DEATH WAS CAUSED BY:	
		4304 Seminole Ave.		IMMEDIATE CAUSE (a) Multiple Stab Wounds	
				DUE TO, OR AS A CONSEQUENCE OF	
				(b) DUE TO, OR AS A CONSEQUENCE OF	
				(c) DUE TO, OR AS A CONSEQUENCE OF	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		11:34 AM 4/28/86		subject stabbed	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		home		4101 Bonner Rd., Baltimore City, Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Gregory R. Kauffman, M.D.		Assistant MEDICAL EXAMINER		4/29/86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
		111 Penn St.		BURIAL	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)	
5-6-86		Cedar Hill		Baltimore	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C. Brown Comm FH		MAY 01 1986		Julia E. Anderson	

52720-00

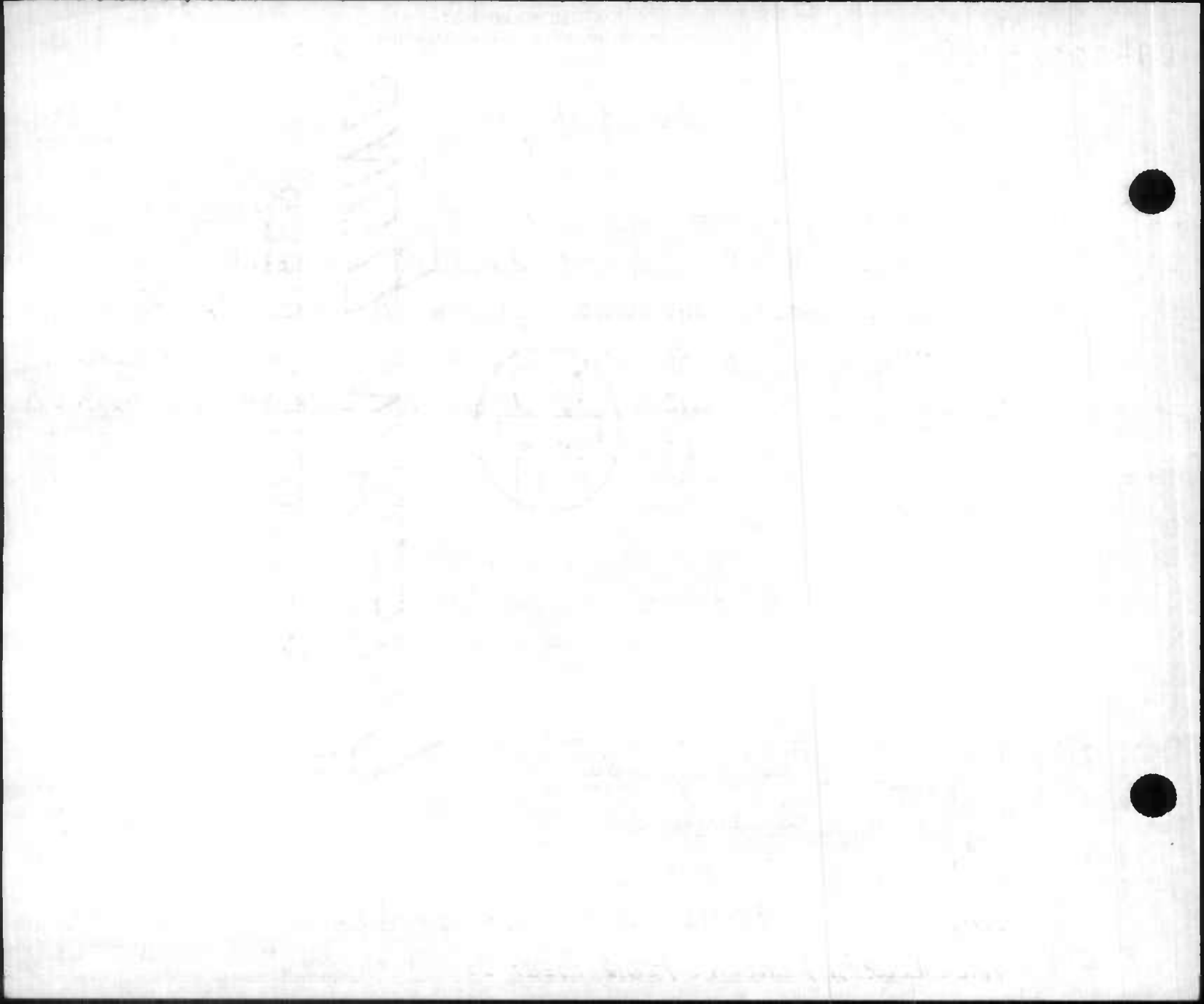


MADE IN U.S.A.

00-021880

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10410  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) ANDRZEJEWSKI Helen ANDREWS		2a. DATE OF DEATH MONTH DAY YEAR 4/1/86		2b. HOUR 10:25 PM	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8/6/08		6. AGE (IN YEARS LAST BIRTHDAY) 77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH F. FATKOWSKI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE MURAWSKI		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-16-4084	
17. INFORMANT CLAUDE ANDRZEJEWSKI		ADDRESS 1810 PARKSIDE DR. PASKIENAPOLIS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		21d. LOCATION CITY OR TOWN COUNTY STATE	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21g. LOCATION CITY OR TOWN COUNTY STATE		21h. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Tullio Emanuele		22c. DEGREE MD		22d. DATE SIGNED 4/1/86	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) TULLIO EMANUELE		22f. ADDRESS 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239		22g. DATE REC'D. BY REGISTRAR APR 08 1986		22h. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/5/86		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD	
24. FUNERAL DIRECTOR NAME KACZOROWSKI FUNERAL HOME		24b. ADDRESS 5525 HEET ST.		24c. DATE REC'D. BY REGISTRAR APR 08 1986		24d. REGISTRAR'S SIGNATURE	



00-03360

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		86 10411							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Catherine or KATHERINE		A		ANDREWS				4 8 86 8:35 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		White		3-21-1899		87			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.				BALTIMORE CITY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		UNION MEMORIAL HOSPITAL				Housewife			
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.		Balto.				1007 S. Clinton St. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
August Burkhard		Walburga Striebeck							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		213-34-2226		Sylvia Semenkiw, 3129 Northway Dr. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Men. Seizures</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>meningitis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4-7, 1986, to 4-8, 1986, that (I) (we) last saw the deceased alive on 4-8, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Janine Good		MD		4-8-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JANINE GOOD M.D.		UNIPN MEMORIAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Entombment		4-10-86		Druid Ridge		Balto., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc., 5305 Harford Rd.				APR 11 1986		Julia Landon-Randall			

NOTICE OF SALE

Notice of

to the

Public

7-11-1957

BY

at

H.A.A.

7

Removal

at

Public

1007 N. Clinton St. Chicago

at

Public

Public

Public

at

7-11-1957

Public Removal, 1007 N. Clinton St. Chicago

Public, 1007

Public, 1007

Public, 1007

Public, 1007

Removal, 1007 N. Clinton St. Chicago

00-03858

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
FOR Film G614 item 1 1- STATE REGISTRAR 4/30/86 rja									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND RONALD CRAIG ANDREWS						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4-14-86 19		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 24 1957		6. AGE (IN YEARS) LAST BIRTHDAY 28 YRS.		7. IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		10. BALTIMORE CITY OR COUNTY OF DEATH MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Arnold's Saw Mill Rt. 140				12a. USUAL OCCUPATION (TYPE OF WORK) Traffic Control Electrician		12b. KIND OF BUSINESS OR INDUSTRY S.H.A.	
13a. STATE Maryland				13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. STREET ADDRESS 750 Eagles Ct. 21157	
14. FATHER'S NAME FIRST MIDDLE LAST Raymond Walter Andrews				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shirley Ann Sapp					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-74-6385		17. INFORMANT ADDRESS Carolyn Andrews 750 Eagles Ct. Westminster, Md. 21157			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:05 AM 4-14-86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of a van which left the roadside striking a fixed object			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) saw mill		21f. CITY OR TOWN Rt. 140 E. of Hemlock Lane Westminster, Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Margarita A. Korell, M.D.				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 4-14-86	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-17-86		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION CITY OR TOWN Westminster Carroll Md.	
24. FUNERAL DIRECTOR NAME John Fletcher				ADDRESS Thomas D. Fletcher & Son F.H. 254 East Main Street Westminster, Md. 21157		25a. DATE REC'D. BY REGISTRAR APR 17 1986		25b. REGISTRAR'S SIGNATURE	

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00-03191

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610413

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen B. Andrys			2a. DATE OF DEATH MONTH DAY YEAR 4 9 86		2b. HOUR 6 A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6-7-22		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. City	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hosp XXX-ital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Retired
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Balto. City	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3231 Glendale Ave., 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Bunder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Lazurcek			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-16-1584	17. INFORMANT ADDRESS Elena S. Pisciotto, 3900 Springarden St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c)			18. Olney, Maryland 20832 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-5, 19 86, to 4-9, 19 86, that (I) (we) last saw the deceased alive on 4-9, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Janine Good		DEGREE MD		22c. DATE SIGNED 4-9-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janine Good, M.D.		22e. ADDRESS Union Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-10-86	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto., MD
24. FUNERAL DIRECTOR John C. Miller, Inc., 6415 Belair Rd. 21206			25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, report any injury or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10414  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH / MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
ELIZABETH E. ANSTINE		F		C	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
3 5 05		81 YRS.		Maryland	
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
USA				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		St. Agnes Hospital		Clerk	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		13b. CITY OR TOWN	
United Ins. Co.		5110 Leeds Ave 21227		Baltimore	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
		George Foos		Emelia UNKNOWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-22-7335		Malcolm S. Anstine, 19 Kempton Road, 21061	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Intracerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 9</u> , 19 <u>86</u> to <u>April 10</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>April 10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
David A. Jung		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
David A. Jung		900 S. Caton Avenue, Balto., Md. 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4/14/86		Glen Haven Mem. Park	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Hubbard Funeral Home, Inc., 4107 Wilkens Ave.		21229		APR 11 1986	
25b. REGISTRAR'S SIGNATURE		25c. COUNTY STATE			
		A.A. Maryland			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10415

1- FOR STATE REGISTRAR		2- DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		3- DATE KNOWN OF DEATH		4- MONTH DAY YEAR		5- HOUR	
		Joseph Anthony				XX 4-18-1986				M	
6- SEX		7- RACE		8- DATE OF BIRTH		9- AGE (IN YEARS)		10- IF UNDER 1 YR.		11- IF UNDER 24 HRS.	
M		B		7 21 53		32		MONTHS DAYS		HOURS MIN	
12- BIRTHPLACE (STATE OR FOREIGN COUNTRY)		13- CITIZEN OF WHAT COUNTRY?		14- MARRIED		15- NEVER MARRIED		16- DIVORCED		17- BALTIMORE CITY OR COUNTY OF DEATH	
S.C.		U.S.A.		YES		NO		YES		Baltimore City	
18- CITY OR TOWN OF DEATH		19- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		20- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		21- KIND OF BUSINESS OR INDUSTRY					
Baltimore		1932 Ridgehill Ave.									
22- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		23- STATE		24- COUNTY		25- CITY OR TOWN		26- STREET ADDRESS		27- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MARYLAND				BALTIMORE				1101 ARGYLE AVE. 21201			
28- FATHER'S NAME		29- MOTHER'S MAIDEN NAME		30- WAS DECEASED EVER IN U.S. ARMED FORCES?		31- SOCIAL SECURITY NO.		32- INFORMANT		33- ADDRESS	
GLEN		ANTHONY		NO		053-52-1003		JIMMIE WILSON		4624 REISTERTOWN RD.	
34- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		35- PART I DEATH WAS CAUSED BY:		36- IMMEDIATE CAUSE (a)		37- DUE TO, OR AS A CONSEQUENCE OF		38- (b)		39- DUE TO, OR AS A CONSEQUENCE OF	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF	
				Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							
				(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
40- DATE OF OPERATION		41- CONDITION FOR WHICH OPERATION WAS PERFORMED?		42- AUTOPSY?							
				YES		NO					
43- EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		44- TIME OF INJURY		45- HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
XX		? P.M. 4-18-1986		Subject stabbed.							
46- INJURY OCCURRED WHILE AT WORK		47- PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		48- LOCATION		CITY OR TOWN		COUNTY		STATE	
XX		Home		1932 Ridgehill Ave.		Balt. City				MD	
49- I certify that I took charge of the remains described above, held on death resulted from:		50- Autopsy		Inspection		Inquiry		and in my opinion			
Natural cause		XX						Undetermined manner			
51- ACTUAL SIGNATURE		52- TITLE (SPECIFY)		53- DATE SIGNED							
Dennis F. Smyth, M.D.		Assistant		4-20-86							
54- EXAMINER'S NAME (TYPE OR PRINT)		55- ADDRESS		56- NAME OF CEMETERY OR CREMATORY		57- LOCATION		COUNTY		STATE	
Dennis F. Smyth, M.D.		111 Penn St., Balt. City MD 21201		MOUNT ZION		LANSDOWNE				MARYLAND	
58- BURIAL, CREMATION, REMOVAL (SPECIFY)		59- DATE		60- NAME OF CEMETERY OR CREMATORY		61- LOCATION		COUNTY		STATE	
BURIAL		4-24-86		MOUNT ZION		LANSDOWNE				MARYLAND	
62- FUNERAL DIRECTOR NAME		63- ADDRESS		64- DATE REC'D. BY REGISTRAR		65- REGISTRAR'S SIGNATURE					
WM.C.MARCH F/H INC.		1101 E.NORTH AVE.		APR 23 1986		J. Davidson					

07/84  
25M

BP

DHMM - 17  
(VR A15 ME (5))

00440-0

CO-1011-1101-05



00-02887

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10416  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Mildred V. Antis</i>			2a DATE OF DEATH MONTH DAY YEAR <i>4 6 86</i>		2b HOUR <i>7:15 PM</i>	
3 SEX <i>Female</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>02-24-24</i>		
6 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>		10 CITY OR TOWN OF DEATH <i>Baltimore</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Francis Scott Key Med. Ctr.</i>		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Banking</i>		13a STREET ADDRESS / ZIP CODE <i>7448 Edsworth Rd. 21222</i>		
13b STATE <i>MD</i>		13c CITY OR TOWN <i>Dundalk</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <i>Arthur Antis</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Uda Bennington</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		
16b SOCIAL SECURITY NO. <i>216-16-6290</i>		17 INFORMANT <i>Earl U. Antis</i>		ADDRESS <i>Same as #13</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Metastatic cancer, renal insufficiency, anemia</i>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <i>4/5</i> 19 <i>86</i> to <i>4/6</i> 19 <i>86</i> that (I) (we) lost saw the deceased alive on <i>4/6</i> 19 <i>86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <i>Charles W. Hoge</i>		DEGREE <i>MD</i>		22c DATE SIGNED <i>4/6/86</i>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles W. Hoge</i>		22e ADDRESS				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>4-10-86</i>		23c NAME OF CEMETERY OR CREMATORY <i>Loudon Pk. Cem.</i>		
23d LOCATION CITY OR TOWN COUNTY STATE <i>Balto. MD</i>		24 FUNERAL DIRECTOR NAME <i>237 E. Patapsco Ave</i> <i>McCully Funeral Homes Balto., MD 21225</i>				
25a DATE REC'D. BY REGISTRAR <i>APR 08 1986</i>		25b REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610417

REG. NO.

1. FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			REG. NO. 8610417						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACOB CHARLES ANTKOWIAK						2a. DATE OF DEATH MONTH DAY YEAR April 24, 1986			2b. HOUR 1235 PM			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JUNE 24, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2429 FLEET STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER			12b. KIND OF BUSINESS OR INDUSTRY INDUS. PAINTING			
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2429 FLEET STREET 21224			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ANTKOWIAK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE STACHOWIAK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS ANNA C. ANTKOWIAK, 2429 FLEET ST. 21224							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic prostate cancer</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>sick senile syndrome requiring pacemaker</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>JAN</i> 19 <i>75</i> to <i>APR</i> 19 <i>86</i> , that (I) <del>was</del> lost saw the deceased alive on <i>APR 3/24</i> 19 <i>86</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <i>did not</i> view the body after death.												
22b. SIGNATURE <i>Paul Chew</i>			DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/25/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL CHW					22e. ADDRESS Francis Scott Key Med Ctr Balto, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4/28/86		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEMETERY BALTIMORE, MARYLAND			23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME George A. Weber & Sons Inc. 705 S. Ann St. 21231					25a. DATE REC'D. BY REGISTRAR APR 25 1986			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Romero</i>				



0-03825

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10418

REG. NO.

1. FOR  
STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)FIRST  
JosephMIDDLE  
LAMBLAST  
Appleby2a. DATE OF DEATH  
4-8-862b. HOUR  
8:15 AM

3. SEX

Male

4. RACE

W.

5. DATE OF BIRTH

MONTH DAY YEAR  
02- 23 06

6. AGE (IN YEARS LAST BIRTHDAY)

80

IF UNDER 1 YEAR

# UNDER 24 HRS

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Keswick

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Salesman

12b. KIND OF BUSINESS OR INDUSTRY

Grocery

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

7003 Bellona Ave. 21212

14. FATHER'S NAME

FIRST MIDDLE LAST  
Joseph Lamb Appleby, Sr.

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Maude Howard

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)

NO

16b. SOCIAL SECURITY NO.

216-09-6050

17. INFORMANT

Nancy A, Willis

ADDRESS  
54 Dendron Rd.

Peace Dale, R.I. 02879

18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 days

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Recurrent Stripes

2 years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Atherosclerosis

years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (the hospital) attended the deceased from 3-12-86 to 4-8-86, that (I) (we) last saw the deceased alive on 4-7-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sew the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

4-8-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Joseph W ZEBLEY

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

April 11, 1986

23c. NAME OF CEMETERY OR CREMATORY

Druid Ridge

23d. LOCATION  
CITY OR TOWN

Pikesville, Baltimore Co., Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212

25a. DATE REC'D. BY REGISTRAR

APR 17 1986

25b. REGISTRAR'S SIGNATURE

[Signature]

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00-05418

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8610419  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Mr. Amos W. Armacost Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 25 1986</b>		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 1 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3805 Seven Mile Lane</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stationary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Engineer</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Balto. City</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Amos W. Armacost Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie May Eckenrode</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-26-2956 A</b>		17. INFORMANT NAME ADDRESS <b>Miss. Hilda Armacost 21208</b> <b>3805 Seven Mile Lane Pikesville Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Extensive pulmonary metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Colon Carcinoma.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>S</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/10/86</b> 19 <b>86</b> , to <b>4/8/86</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/8/86</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>A. Hussain</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/28/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. HUSSAIN</b>		22e. ADDRESS <b>22 S. GREENE ST., BALT., MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>04-29-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Baltimore Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 29 1986</b>		
8728 Liberty Road Randallstown, Maryland 21133			25b. REGISTRAR'S SIGNATURE <b>John Davidson-Hendall</b>		

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0-04569

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10420  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BEATRICE L. ARMACOST</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 22 86</b>		2b. HOUR <b>7<sup>00</sup> PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 28 07</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>78</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY,</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MACHINE OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>21239</b>		
13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>5917 GLEN KIRK RD. 21239</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>JACOB SELLERS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAMIE HAHN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-18-6127</b>		17. INFORMANT ADDRESS <b>RUSSELL J. ARMACOST 5917 GLEN KIRK RD. 21239</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

**PULMONARY EDEMA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) **CONGESTIVE HEART FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

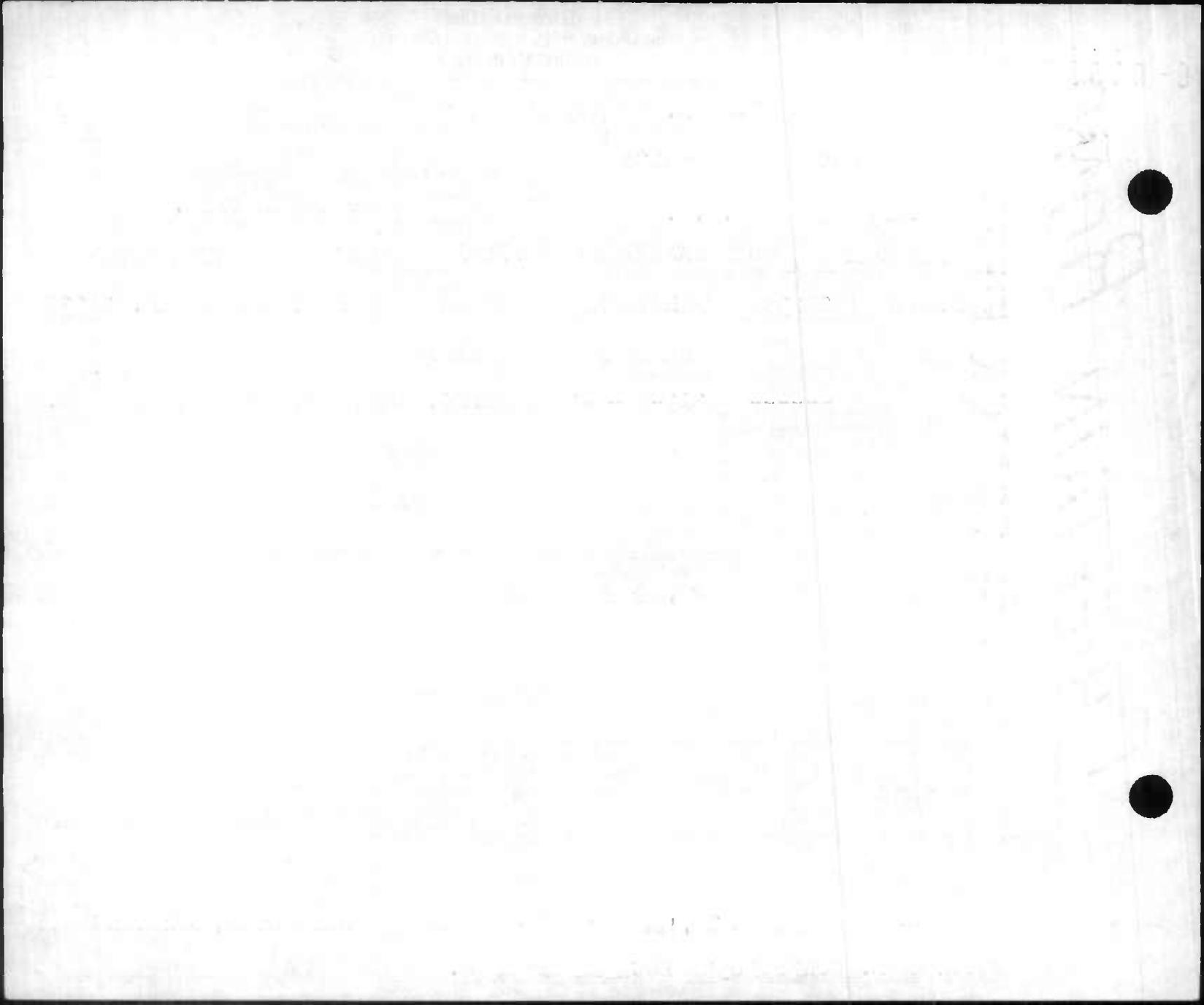
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**MULTIPLE MYELOMA, STROKE, DIABETES MELLITUS**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 12, 19 86</b> , to <b>APRIL 22, 19 86</b> , that (I) (we) last saw the deceased alive on <b>APRIL 22, 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ramsay Kurban</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/22/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAMSAY KURBAN</b>		22e. ADDRESS <b>% Good SAMARITAN HOSPITAL</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APRIL 26, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>IMMANUEL CEMETERY MANCHESTER, MARYLAND</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>WILLIAM E. JOHNSON</b>		ADDRESS <b>8521 LOCH RAVEN BLVD.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 24 1986</b>		25b. REGISTRAR'S SIGNATURE <i>G. Davidson-Randall</i>	

BP





0-03654

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				86 10421	
1- FOR STATE REGISTRAR		REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR	
Berry		Armfield		4 12 86 1 45 PM	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS.	
Male	Black	8 3 07		78	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
N.C.	USA			Baltimore City MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)	
Baltimore		Luthran Hospital		Retired	
13a STATE		13b CITY OR TOWN		13c STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		3609 W. Saratoga St 21229	
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Gus		Betty			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
NO		246-18-0591		Mary A. Williams 3609 W. Saratoga	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiorespiratory arrest					
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis					
DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of Lung with met.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/12 1986 to 4/12 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
R. Girgis				4/12	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
RAAFAT X. GIRGIS		Luthran Hospital - Baltimore			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4-19-86		Community Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Tarboro N.C.		APR 15 1986		Jana Gordon-Parker	
24 FUNERAL DIRECTOR NAME		24a ADDRESS		24b DATE REC'D. BY REGISTRAR	
WM. E. MARCH F.H.		4300 WABASH AVE			

47880



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 1 0 4 2 2

0-04312

1 DECEASED NAME (TYPE OR PRINT) Beecher Arms			2a. DATE OF DEATH MONTH DAY YEAR April 20 86			2b. HOUR M				
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 15 11		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center millright				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beth. Steel		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7268 Ridgewood Dr. 21224		
14. FATHER'S NAME FIRST MIDDLE LAST Sam K. Arms			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arminta A. Rivers			16a. SOCIAL SECURITY NO 400-18-3380				
16b. DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16c. SOCIAL SECURITY NO 400-10-3380			17. INFORMANT June Arms			18. ADDRESS same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF C.O.P.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CARCINOMA OF LUNG - CHOLELITHIASIS										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED 4/21/86		
22a. I certify that (I) (this hospital) attended the deceased from 7/1/84 19 to 4/3/86 19, and that (I) (we) last saw the deceased alive on 4/3/86 19, and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Max Traub, M.D.			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 4/21/86	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) MAX TRAUB, M.D.			22g. ADDRESS 7422 EASTERN AVE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-22-86		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Inc 7922 Wise Ave Balto Md						25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE Guthrie Davidson		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

BP

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page. The text is mostly centered and spans several lines.]*

00-05255

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10423	
1- FOR STATE REGISTRAR <u>A.L. Per phone</u>											
1. DECEASED NAME FIRST MIDDLE LAST <u>Thomas</u> <u>Armstrong</u>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <u>4</u> <u>24</u> <u>19</u> <u>86</u>	
3. SEX <u>Male</u> 4. RACE <u>Black</u> 5. DATE OF BIRTH MONTH DAY YEAR <u>08-07-1939</u> 6. AGE (IN YEARS) LAST BIRTHDAY <u>46</u> YRS.										2b. HOUR <u>9:20</u> AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Balto., Md.</u> 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <u>4</u> <u>24</u> <u>19</u> <u>86</u>	
10. CITY OR TOWN OF DEATH <u>Baltimore</u> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>1358 Cleveland St.</u> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Playboy</u> 12b. KIND OF BUSINESS OR INDUSTRY										9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD	
13a. STATE <u>Maryland</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Baltimore</u> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <u>1358 Cleveland St.</u> 21230											
14. FATHER'S NAME FIRST MIDDLE LAST <u>Will</u> <u>Armstrong</u> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Jean</u> <u>Armstrong</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>Yes</u> 16b. SOCIAL SECURITY NO. <u>212-34-6474</u> 17. INFORMANT <u>Jean Armstrong</u> ADDRESS <u>1358 Cleveland Street</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure disorder and cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a. <u>Chronic renal disease</u>											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Dennis F. Smyth</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED <u>4-24-86</u>											
EXAMINER'S NAME (TYPE OR PRINT) <u>Dennis F. Smyth, M.D.</u> ADDRESS <u>111 Penn St., Balto., MD 21201</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> 23b. DATE <u>05-01-86</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Crownsville Va. Cem.</u> 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Crownsville, Maryland</u>											
24. FUNERAL DIRECTOR NAME ADDRESS <u>Brown/Thompson F.H.</u> <u>1913 W. Baltimore Street</u> 25a. DATE REC'D. BY REGISTRAR <u>APR 30 1986</u> 25b. REGISTRAR'S SIGNATURE											

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

48370



00-05355

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10424

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BETTY JEAN ARRINGTON			2a DATE OF DEATH MONTH DAY YEAR APRIL 27, 1986		2b HOUR 11:11 AM
3 SEX M	4 RACE B	5. DATE OF BIRTH MONTH DAY YEAR 8 27 43		6 AGE (IN YEARS LAST BIRTHDAY) 42 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C..	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD	
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b KIND OF BUSINESS OR INDUSTRY
13a STATE MARYLAND	13b COUNTY	13c CITY OR TOWN BALTIMORE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 1045 BROADWAY 21205	
14 FATHER'S NAME FIRST MIDDLE LAST EDWARD ARRINGTON		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELEANOR JOHNSON			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212427039	17 INFORMANT ADDRESS MILDRED ARRINGTON 1036 BROADWAY		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>PULMONARY EMBOLI VERSUS PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MORBID OBESITY</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (he, she) attended the deceased from <u>APRIL 25</u> , 19 <u>86</u> , to <u>APRIL 27</u> , 19 <u>86</u> , that (he, she) lost saw the deceased alive on <u>APRIL 27</u> , 19 <u>86</u> and that in (my, our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.					
22b SIGNATURE <i>George Karkar</i>		DEGREE		22c DATE SIGNED APRIL 27, 1986	
22d PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE KARKAR		22e ADDRESS CHURCH HOSPITAL CORPORATION BALTIMORE, MARYLAND 21231			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 5-3-86	23c NAME OF CEMETERY OR CREMATORY EASTVIEW		23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24 FUNERAL DIRECTOR NAME WM.C.MARCH F/H INC. 1101 E. NORTH AVE.		25a DATE REC'D. BY REGISTRAR MAY 1 1986			
		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			





00-04235

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

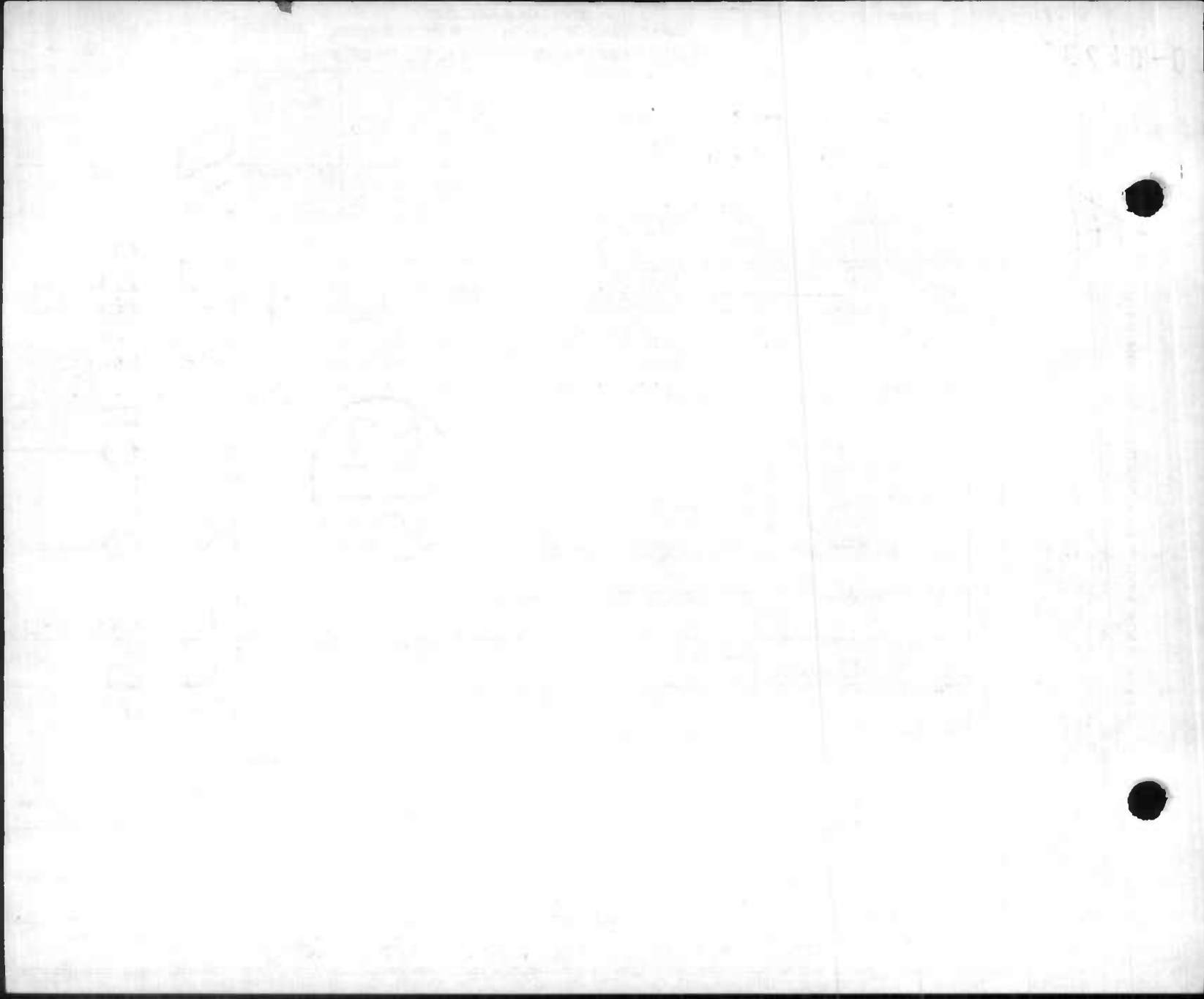
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 17M-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 104235
1- FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard E. Ashcraft						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4/17/1986		2b. HOUR M		
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Mar. 8, 1941		6. AGE (IN YEARS) (LAST BIRTHDAY) 45 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4/18/1986		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 852 W. Lombard St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. STATE Maryland		13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 852 W. Lombard St. 21201		
14. FATHER'S NAME FIRST MIDDLE LAST Edwin B. Ashcraft				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wanda Zinn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes-Army				16b. SOCIAL SECURITY NO. 233-62-4041		17. INFORMANT (Sister) Betty Riggs		ADDRESS Rt. 3 26554 Fairmont, W. Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ethanolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 4/19/86		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/21/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fairmont Marion W. Va.				
24. FUNERAL DIRECTOR Fleming Funeral Service				ADDRESS 21018 Benson, Md.		25a. DATE REC'D. BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE <i>J. Davidson</i>		

07/B4  
25M

BP

DHMH - 17  
(VR A15 ME (5))



00-04392

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 86 10426			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Olive E. Ashley				2b. HOUR 4:00 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 30 99		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ESK Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY Balt		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William E. Ashley, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Rowe		13e. STREET ADDRESS / ZIP CODE 21 Mobile Lodge Drive 21222			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 176-09-4042		17. INFORMANT William E. Ashley, Jr. Same as 13e			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AMI							
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/5, 19 86, to 4/16, 19 86, that (I) (we) last saw the deceased alive on 4-16-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Howard Tuch MD				DEGREE MD		22c. DATE SIGNED 4-16-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Tuch				22e. ADDRESS 2000 Oak Hill Ave Balt 21222			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/19/1986		23c. NAME OF CEMETERY OR CREMATORY Westview		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 22 1986			
7922 Wise Avenue Dundalk, Maryland 21222							

BP

02-04303

4-10-84

12/28/84

Oliver E.

88

PP 25

White

1/20/84

AW

25K Medical Care

1/20/84

1/20/84

1/20/84

NOTES

1/20/84

900-052281

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

10427

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST ROSE	MIDDLE Frances	LAST ASHTON	2a. DATE OF DEATH MONTH DAY YEAR APRIL 26, 1986		2b. HOUR P 8:40 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 2, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier		12b. KIND OF BUSINESS OR INDUSTRY Department Store		13a. STREET ADDRESS / ZIP CODE 800 S. Main St. 21014		13b. CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME FIRST MIDDLE LAST John Weglein		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Marachoski		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 28 3856		17. INFORMANT ADDRESS Joseph Ashton Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intractable ventricular tachycardia/fibrillation</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myocardial infarction</u> <u>48 hrs.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u> <u>5 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>right ventricular infarction, diabetes, obesity.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>86</u> , to <u>4/26</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>4/26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Michael N. Drossner</u>				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/26/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL N. DROSSNER, M.D.				22e. ADDRESS 600 n. WOLFE ST. BALTO. MD. 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4/30/86		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR <u>Brazdzinski Funeral Home PA 1407 Old Eastern Ave</u>				25a. DATE REC'D. BY REGISTRAR APR 30 1986		25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u>			

88-02220

100 105 P

2008 11/15/10

DEPT ACTION

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00-03996

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15. 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		86		10428		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence M. Austin				2a. DATE OF DEATH MONTH DAY YEAR 4/14/86		2b. HOUR 3:30 P.M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 5 36		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balt.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Herbert Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Austin		13e. STREET ADDRESS / ZIP CODE 1836 Clifton Ave 21217					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 224-40-9466		17. INFORMANT Isabelle Austin		ADDRESS 1836 Clifton Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma 7 lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Respiratory failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/15/86</u> 19 <u>86</u> , to <u>4/16</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Moges Gebremariam				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/19/86		23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F.H West 4300 Wabash Ave				25a. DATE REC'D. BY REGISTRAR APR 18 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

68005-00

2000 COLLECTION



00-02422

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as directed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10429

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Peggy Cleo Ayres		April 1, 1986		8:00 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	May 1, 1923	62 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Mercy Hospital		Clerical		Accounting Alexander Grant
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	City	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	524 N. Charles Street 21201	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		17. INFORMANT		
Frank A. Sparrow	Lydia F. Masomer		(Sister) 1416 Gordon Drive		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	Mrs. Catherine Peterson Glen Burnie, Md.			
No	215.16.2749				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:			21061		
IMMEDIATE CAUSE (a) <u>Septic</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchogenic Carcinoma of lung with metastasis</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral ischemia</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebral ischemia</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 1, 1986</u> to <u>Apr 1, 1986</u> , that (I) (we) last saw the deceased alive on <u>Apr 1, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
<u>[Signature]</u>					<u>4.1.86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
<u>Dr. S. C. H. A.</u>	2900 E. Bayview St.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY STATE	
Burial	Apr. 4, 1986	Meadowridge Mem. Park	Elkridge	Howard	Md.
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
NAME Singleton Funeral Home	APR 3 1986		<u>[Signature]</u>		
Glen Burnie, Maryland					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be returned to you within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				86 10430 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>VICTOR William BACKUS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 5 86</b>	
3 SEX <b>MALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 22 18</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. <b>67 YRS.</b>	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LOCH RAVEN VA MC</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City MD</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>Maryland</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>unknown Backus</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Letsinger</b>		13e STREET ADDRESS / ZIP CODE <b>4710 Harford Road 21214</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW II</b>		16b SOCIAL SECURITY NO. <b>216-10-9332</b>		17. INFORMANT ADDRESS <b>Doris M. Cox same as 13e</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> <b>912</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ASPIRATION</b> (c) <b>LIVER CIRRHOSIS &amp; SEVERE ASCITES</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MIN</b> <b>MIN - hours</b> <b>months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>3/13</b> , 19 <b>86</b> , to <b>4/5</b> , 19 <b>86</b> that (I) (we) lost saw the deceased alive on <b>4/5</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Shayna Lee MD</b>				22c DATE SIGNED <b>4/5/86</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Shayna Lee MD</b>				22e ADDRESS <b>Loch Raven VA MC</b>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>4/8/1986</b>		23c NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Veterans</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Baltimore, MD</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Owings Mills Balto., MD</b>		25a DATE REC'D. BY REGISTRAR <b>APR 7 1986</b>	
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10431

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Genevieve WAGNER Baile</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-13-86</b>			2b. HOUR <b>11:00 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 17 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>WAREHOUSE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LITERARY</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MO</b>		13c. CITY OR TOWN <b>Westminster</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>338 Ridge Road 21057</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Emory M. Wagner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Mullin</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-10-7752</b>		17. INFORMANT ADDRESS: <b>CHESTERFIELD, VA 23832</b> <b>CAROLYN FORBES 10700 TRAILWOOD DRIVE</b>	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART 1: DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) **Metastatic Breast Cancer**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**19 yrs**

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

**Pulmonary Embolus Gastrointestinal Hemorrhage, Deep Vein Thrombosis, Renal Abscess**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>March 15 1986</b> to <b>April 13 1986</b> , that (we) lost saw the deceased alive on <b>April 13 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Russell R. DeLuca</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/13/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Russell R. DeLuca</b>		22e. ADDRESS <b>22 South Greene Street</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4-17-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINE GROVE CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MT. AIRY CARROLL MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>ROBERT A. MYERS 91 WILKES ST. WESTMINSTER MARYLAND</b>				25. DATE REC'D. BY REGISTRAR <b>APR 18 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John DeLuca</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove both pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked item 18, above any injury, or other traumatic cause, the medical examiner must be notified at once.

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20% COTTON FIBRE

00-03993

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

10432

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bennett Nelson Bailey, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 4-11-1986		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11-11-1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Hopkins		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Utility Worker		12b. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Electric
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Bennett N. Bailey, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-09-6715		17. INFORMANT ADDRESS 404 E. 22nd Street Baltimore, Maryland 21218	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HCD Diabetes mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/6/80</u> to <u>March 6, 1986</u> , that (I) (we) last saw the deceased alive on <u>3/6/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>F. C. CAGUIN, M.D.P.A.</u>		22e. ADDRESS <u>230 E. 25th St.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-18-1986	23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR <u>Nutter &amp; Sons</u> 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216			25a. DATE REC'D. BY REGISTRAR <u>APR 18 1986</u>		
			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

29

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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PALESTINE JOURNAL

2000-00-00

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 3 and 4, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 120, and 121, 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MEDICAL CERTIFICATION

1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 6 1 0 4 3 3 REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) <i>Emma Viola Bailey</i>			2a DATE OF DEATH MONTH / DAY / YEAR <i>4 / 9 / 86</i>		2b HOUR <i>10:10 PM</i>
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH MONTH / DAY / YEAR <i>7 / 5 / 07</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>78</i>	IF UNDER 1 YEAR MONTHS / DAYS / HOURS / MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Balto City</i> MD.	
10 CITY OR TOWN OF DEATH <i>Balto</i>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Marion F. Lord (FSKMC)</i>		12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Housework</i>
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i>			13b COUNTY <i>Baltimore</i>	13c CITY OR TOWN <i>Dundalk</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST / MIDDLE / LAST <i>Casper / Long</i>			15 MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST <i>Viola / Cummings</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>213-30-6375</i>		17 INFORMANT ADDRESS <i>Joseph Bailey 411 S. Central Ave. 21202</i>	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Dementia</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>4/9/86</i> to <i>4/9/86</i> , that (I) (we) last saw the deceased alive on <i>4/9/86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b SIGNATURE <i>Linda P. Fried</i>		DEGREE <i>M.D.</i>		22c DATE SIGNED <i>4/10/86</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>LINDA P. FRIED M.D.</i>		22e ADDRESS <i>5200 Eastern Avenue</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>4-12-86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Eastwood, Balto. Co., Md.</i>	
24 FUNERAL DIRECTOR NAME <i>Charles S. Zeiler &amp; Son Inc.</i>		ADDRESS <i>901 S. Conkling St</i>		25a DATE REC'D. BY REGISTRAR <i>APR 11 1986</i>	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10434

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH WILLIAM BAILEY</b>			2a. DATE OF DEATH <b>April 24, 1986</b>		2b. HOUR <b>11:51</b> <small>M</small>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Oct. 8, 1901</b> <small>MONTH DAY YEAR</small>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> <small>YRS</small>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Montana</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> <small>MD</small>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Jockey -- Horseracing</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>	13b. COUNTY	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>423 W. Saratoga St., 21201</b>	
14. FATHER'S NAME <b>Charles</b> <small>FIRST</small> <b>Bailey</b> <small>MIDDLE</small> <b>Bailey</b> <small>LAST</small>		15. MOTHER'S MAIDEN NAME <b>Margaret</b> <small>FIRST</small> <b>Clark</b> <small>LAST</small>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>266 36 6738</b>		17. INFORMANT <b>Mary M. McIntyre, Balto., MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable acute myocardial infarct</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerosis cardiovascular</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Ventricular arrhythmia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) this hospital attended the deceased from <b>Jan 86</b> to <b>present</b> , that (b) we last saw the deceased alive on <b>Jan 86</b> , and that in (b) our opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Refusing</b>		DEGREE <b>no</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/28/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Rifat Abousy, MD</b>		22e. ADDRESS <b>2300 Garrison Blvd, Balto., MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>4/28/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., MD</b>	
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b> <b>4905 York Road Balto., MD 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 29 1986</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U F W I I E Y April 1961  
White USA Baltimore  
University Hospital  
Baltimore  
Charles  
Mary M. Moore, Baltimore  
Clare

Dr. Fife about 1961  
Green Mount  
Harry W. Jordan & Son Co.  
New York Road, Baltimore, Md. 21212  
Dr. Fife about 1961  
Green Mount  
Harry W. Jordan & Son Co.  
New York Road, Baltimore, Md. 21212

00-04346

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

10435

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LILLIAN EDNA BAILEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 19 86</b>		2b. HOUR <b>12.30PM</b>
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 25 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. <b>68 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Health Care</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <b>Maryland Baltimore Woodlawn</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13b. STREET ADDRESS <b>1137 Dorchester Avenue 21207</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline Dannenhauer</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-22-3280</b>		17. INFORMANT ADDRESS <b>Alfred Bailey Same as # 13</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CARCINOMA TO LUNGS</b>		<b>MONTHS</b>
(c) <b>ADENOCARCINOMA CARCINOMA</b>		<b>MONTHS</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

19a. DATE OF OPERATION <b>—</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/16</b> 19 <b>86</b> , to <b>4/19</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/19</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Steven H. Pearlman</b>		DEGREE <b>M.D.</b>	22c. DATE SIGNED <b>4/19/86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN H. PEARLMAN</b>		22e. ADDRESS <b>ST. AGNES HOSPITAL 800 S. CATON AVE.</b>	

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4/23/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Carroll Maryland</b>
24. FUNERAL DIRECTOR'S NAME <b>Leroy M. &amp; Russell C. Witzke</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 22 1986</b>	
24. FUNERAL HOME <b>Funeral Homes P.A.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
1630 Edmondson Avenue, Catonsville, MD. 21228			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a copy of the certificate must be furnished to the medical examiner.



10-04681

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10430  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Georgia B BAIN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4-17-86</b>		2b. HOUR <b>3:50 A.M.</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 5 95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Resnick</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS / ZIP CODE <b>1101 N. Calvert St. 21202</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Washington Bain</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>548-16-4165</b>		17. INFORMANT ADDRESS <b>Miss Jeanne Fisher 501 W. University 21210</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF b) <b>coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF c) <b>34 years</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-17</b> , 19 <b>86</b> , to <b>4-17</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4-16</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>E. J. H. Wiedefeld</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-17-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/19/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air Harford Md.</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 24 1986</b>			
25b. REGISTRAR'S SIGNATURE <b>J. W. Wiedefeld</b>							

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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00-03491

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10437

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elsie</b>		FIRST <b>c.</b>		MIDDLE <b>Baker</b>		LAST <b>Baker</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4-12-86</b>				2b. HOUR <b>5:30</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 25 1899</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>				7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>				MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Perring Parkway Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Weaver</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Hooper &amp; Sons</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3365 Chestnut Avenue 21211</b>					
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Bond</b> LAST <b>Bond</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b>Mary</b> LAST <b>Schultz</b>				16. ADDRESS <b>21221</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) <b>--</b>		17. INFORMANT <b>Mr. Mel Widerman</b>		17. ADDRESS <b>1301 Wildwood Beach Rd.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>A.S. C. V.D.</b>												<b>YEARS</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>SYBARACHNOID BLEED</b>												<b>MONTHS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (1)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/13</b> , 19 <b>86</b> , to <b>4/12</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/12</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>B.C. VENERACION JR</b>								DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/12/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B.C. VENERACION JR</b>								22e. ADDRESS <b>3401 DUNDALK AVE BALTO MD 21222</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4/15/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Manchester Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Manchester</b>		COUNTY STATE <b>Carroll Co. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>A. Alan Seitz, Jr.</b>								ADDRESS <b>3615-19 Chestnut Ave. 21211</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 14 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP



00-05349

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 10438

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RIGNAL Woodward . BALDWIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>04 26 86</b>		2b. HOUR <b>10-35pm</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 -12-02</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		
10 CITY OR TOWN OF DEATH <b>MARYLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KESWICK NURSING NURSING HOME</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, MARYLAND</b> MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ATTORNEY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LAW</b>				
13a STATE <b>MARYLAND</b>		13b COUNTY <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Rignal W. Baldwin, Sr.</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Augusta Hopkins</b>		13d. STREET ADDRESS / ZIP CODE <b>1100 W. LAKE AVE. 21210</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW 11 218-26-0434</b>		17 INFORMANT ADDRESS <b>Ann W. Baldwin Same</b>		
18 CAUSE OF DEATH (Enter only one cause per line for 18a and 18b) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>synphoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>6 months</b>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (if this hospital) attended the deceased from <b>11-19</b> , 19 <b>85</b> , to <b>4-26</b> , 19 <b>86</b> , that (1) (we) last saw the deceased alive on <b>4-26</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did not touch the body after death.						
22b SIGNATURE <b>[Signature]</b>		DEGREE <b>[Signature]</b>		22c DATE SIGNED <b>IV 2686</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>April 29, 1986</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baldwin Memorial Church Millersville A.A. Co., Md.</b>		
23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>		23e ADDRESS <b>700 W 40th Street Balto Md 21211</b>		23f DATE REC'D. BY REGISTRAR <b>MAY 1 1986</b>		
24 FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>		24a ADDRESS <b>6500 York Rd.</b>		24b REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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00-03245

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10439

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sallie G. Banks			2a. DATE OF DEATH MONTH DAY YEAR 4/9/86		2b. HOUR 10:15A M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 15 15		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Balt	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. CITY OR TOWN Balt		
14. FATHER'S NAME FIRST MIDDLE LAST Matthew Harris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie Mae		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-26-8863		17. INFORMANT ADDRESS Delores Berry 4116 Mountwood Road	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac/pulm arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis/pneumonia		5 days
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes out of control		5 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Epidermoid Cancer of maxillary sinus - incurable			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/5, 19 86, to 4/9, 19 86, that (I) (we) last saw the deceased alive on 4/9, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE H. Rosen MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 4/9/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Rosen MD		22e. ADDRESS 225 Greene St 21201	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/12/86	23c. NAME OF CEMETERY OR CREMATORY King Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md
24. FUNERAL DIRECTOR NAME William C. March F/H West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR APR 10 1986	
		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Office of the Secretary of the Interior

10

United States Department of the Interior

Washington, D.C.

February 10, 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 7th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration. I am, Sir, very respectfully,  
Yours very truly,  
John D. Rockefeller

Very truly yours,  
John D. Rockefeller

John D. Rockefeller

John D. Rockefeller

00-04373

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10440

REG. NO.

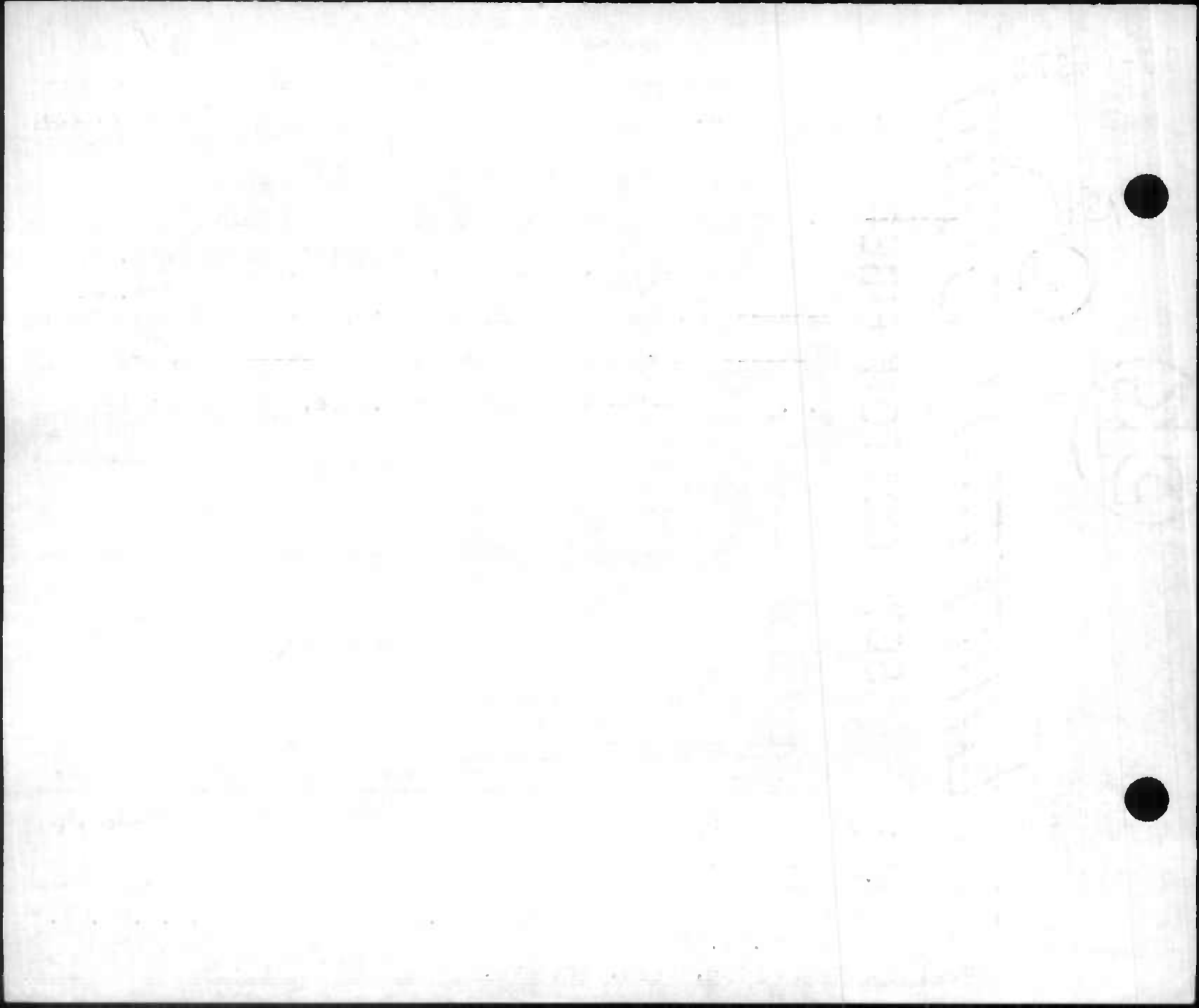
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Francis J. Barnes</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4-20-86</i>		2b. HOUR <i>12:22AM</i>		
3. SEX <i>male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6-24-21</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>64</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Baltimore General</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Administrator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Beth.Steel</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Barnes</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Gault</i>		13e. STREET ADDRESS / ZIP CODE <i>Balto.Md. 21230</i>		13f. <i>2752 Marlborough Ave</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes W.W.2</i>		16b. SOCIAL SECURITY NO. <i>215-16-0146</i>		17. INFORMANT <i>Kathleen P.Hare, Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. Rurian</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>4-20-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Rurian</i>				22e. ADDRESS <i>3001 S. Hanover</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/23/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie, A.A.Co.Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Balto.Md.21230</i>				25a. DATE REC'D BY REGISTRAR <i>APR 22 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Jana Davidson</i>	
26. ADDRESS <i>McCully Funeral Home, 130 E. Fort Ave.</i>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and asked to examine the body.

BP





0-03908

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

10441

1. DECEASED NAME (TYPE OR PRINT) John C. Barnes			2a. DATE OF DEATH MONTH DAY YEAR 4/15/86		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 11 11		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1817 Moreland Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2710 East Preston Street 21213
14. FATHER'S NAME FIRST MIDDLE LAST JOHN SPENCER BARNES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATILDA CARROLL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 239-03-8417		17. INFORMANT ADDRESS JOHN A. BARNES 4504 NORFOLK AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO R. &amp; ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Ch. Ischemic CARDIOmyopathy &amp; CABG.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ch. Heart block</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-15-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. A. Fikow		22e. ADDRESS 2236 Blvd Bn 28 in 21221			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4-18-86	23c. NAME OF CEMETERY OR CREMATORY MARYLAND NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL MARYLAND	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR APR 17 1986	
		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

14 AC:

03810



00-03728

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		86		10442		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VINNIE BARNES					2a. DATE OF DEATH MONTH DAY YEAR 9/15/86			2b. HOUR 2:59A.M.	
3. SEX F		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12/12/07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Miss		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 23 N. Calhoun St 21223	
14. FATHER'S NAME FIRST MIDDLE LAST DAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearlie Crawford		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown		16b. SOCIAL SECURITY NO. 360-22-0878		17. INFORMANT ADDRESS admission sheet	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest sec. DUE TO, OR AS A CONSEQUENCE OF (b) Anoxia sec to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Respiratory pneumonia, multiple myeloma, chronic renal failure 6 months					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 2 1/2 hrs				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1979 to 9/15/86, that (I) (we) lost saw the deceased alive on 9/14/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. McInnes		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/15/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. McInnes MD				22e. ADDRESS 3721 Potomac Rd Baltimore MD 21225					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/18/06		23c. NAME OF CEMETERY OR CREMATORY Garden of Eternity / 1540 Kingsdome Rd		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Mr. Hays 638 N 91st St				25a. DATE REC'D. BY REGISTRAR APR 16 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



*[Faint, illegible handwritten text covering the majority of the page.]*

00-03386

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10443  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANNIE S. BARNETT</b>			2a DATE OF DEATH MONTH DAY YEAR <b>4 8 86</b>		2b HOUR M <b>M</b>
3 SEX <b>F</b>	4 RACE <b>B</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>5 08 05</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>80</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY</b>	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>946 NORTH CHAPEL STREET</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE</b>		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <b>MARYLAND</b>	13c COUNTY	13d CITY OR TOWN <b>BALTIMORE</b>	13e INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13f STREET ADDRESS / ZIP CODE <b>946 N. CHAPEL STREET 21205</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOHN H. HARRIS</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY J. LEVY</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b SOCIAL SECURITY NO. <b>213-28-6770</b>		17 INFORMANT ADDRESS <b>MARY A. MITCHELL 2904 OAKFORD AVE.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF <b>CARCINOMA OF PANCREAS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>WITH PYLORIC OBSTRUCTION</b> (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a DATE OF OPERATION <b>X</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>X</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>X</b>	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>10-15</b> , 19 <b>85</b> , to <b>April 19, 86</b> , that (I) (we) last saw the deceased alive on <b>4/19</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Mesbah U Dawla</i>		DEGREE <b>MD</b>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>MESBAH U DAWLA</b>		22e ADDRESS <b>100 N. BROADWAY, Ball 21231</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>4-12-86</b>		23c NAME OF CEMETERY OR CREMATORY <b>MARYLAND NATIONAL</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>LAUREL MARYLAND</b>					
24 FUNERAL DIRECTOR NAME <b>WM.C.MARCH F/H INC.</b>		ADDRESS <b>1101 E. NORTH AVE.</b>		25a DATE REC'D. BY REGISTRAR <b>APR 11 1986</b>	

MEDICAL CERTIFICATION

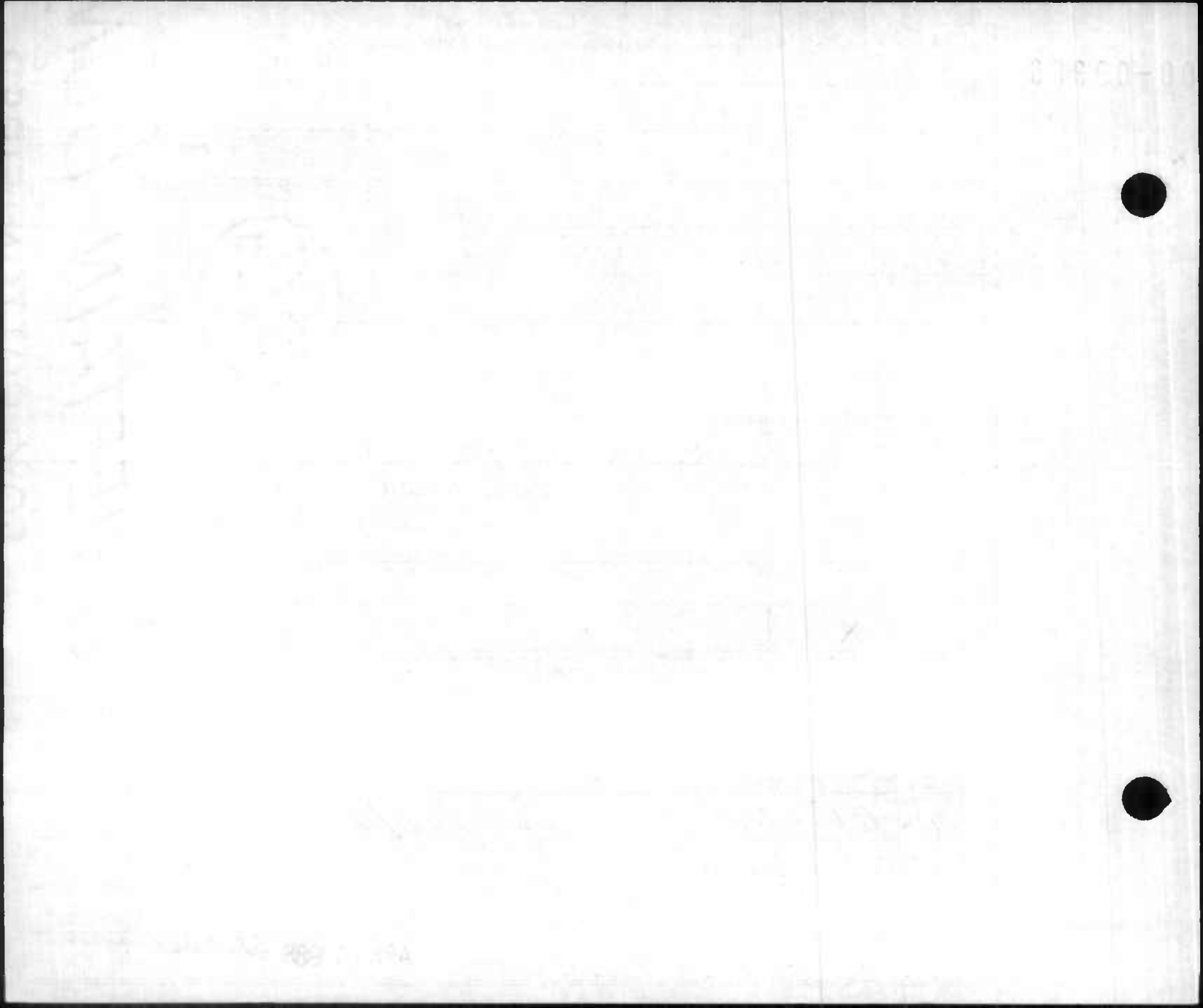
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



00-03458

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610444

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN Marie BARRETT			2a. DATE OF DEATH MONTH DAY YEAR APRIL 8, 1986		2b. HOUR P M 3:43 P					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 706 Beards Hill Rd. / 21001	
14. FATHER'S NAME FIRST MIDDLE LAST Russell Weeks			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta Parsells			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO N/A				
16b. SOCIAL SECURITY NO. 137-14-6866			17. INFORMANT George S. Barrett, Same as Above					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ischemic cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>1 year</u> <u>10 years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>4/8</u> , 19 <u>86</u> , to <u>4/8</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>4/8</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>Abbie Herskowitz</u>				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/8/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abbie Herskowitz				22e. ADDRESS Johns Hopkins Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford, Maryland				
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399				25a. DATE REC'D. BY REGISTRAR APR 14 1986		25b. REGISTRAR'S SIGNATURE				

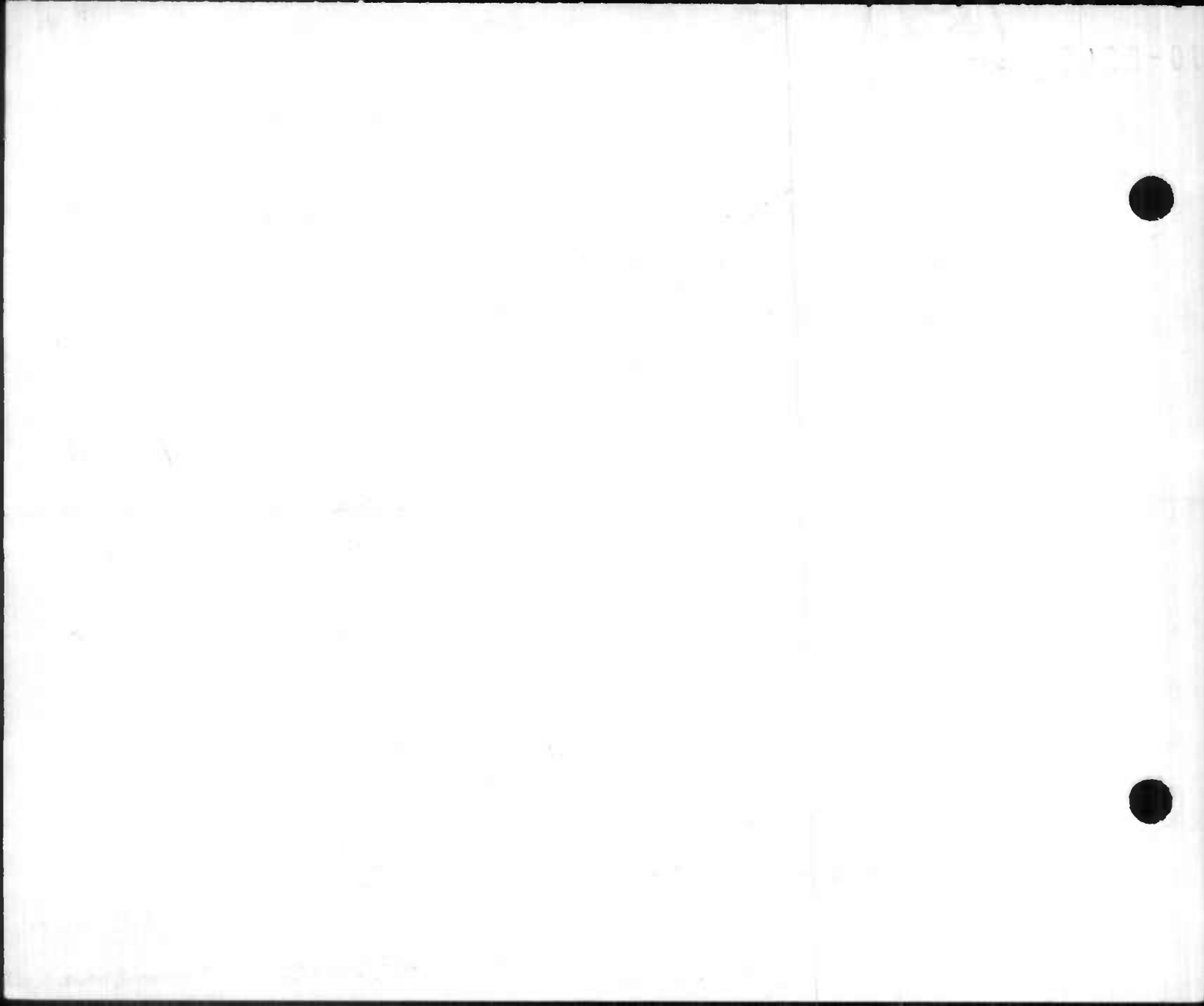
BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





00-024985

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be placed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a necropsy performed.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8610445  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Emma Sylvania Barry			2a. DATE OF DEATH MONTH DAY YEAR 4 / 01 / 86		2b. HOUR 2:17 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 2 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Baumberger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 219-28-3700		17. INFORMANT ADDRESS Sylvania Miller, 225 S. Duncan St. 21231	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Caido Pulmonary Arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min.
DUE TO, OR AS A CONSEQUENCE OF (b) Bleeding Duodenal Ulcer					2 Wks. n.
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) Pyloroplasty					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/12, 19 86, to 4/1, 19 86, that (I) (we) lost saw the deceased alive on 4/1, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Wheeler Adesca MD				22c. DATE SIGNED 4/01/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MUTTER ADOLPH				22e. ADDRESS Church Hospital, 100 N. Broadway 21231	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/04/86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County Md.		23e. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery			
24. FUNERAL DIRECTOR NAME Lilly & Zeiler, Inc. 1901 Eastern Ave. 21231		25a. DATE REC'D. BY REGISTRAR APR 03 1986		25b. REGISTRAR'S SIGNATURE	

BP

NOTED 10/10/00

00-03778

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 10446
1- FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST JOHN BARTEE			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 2 1986			2b. HOUR M M
3. SEX MALE	4. RACE COL	5. DATE OF BIRTH MONTH DAY YEAR 4-1-32	6. AGE (IN YEARS) LAST BIRTHDAY 54 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 3 1986			2d. HOUR A M 10:45			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MO			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 815 N. Chapel St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE MARYLAND			13b. COUNTY			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 822 N. CASTLE ST. 21213
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS BARTEE						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDWARTA BARTEE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1952-1954			17. INFORMANT ADDRESS MR. KEITH BARTEE 3426 VIRGINIA AVE. 21215						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure disorder</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Ethanolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <i>Dennis F. Smyth M.D.</i>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 4-3-86			
EXAMINER'S NAME (TYPE OR PRINT)			Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., MD 21201						
23a. BURIAL, CREMATION, REMOVAL (BY)			23b. DATE 4-14-86			23c. NAME OF CEMETERY OR CREMATORY GARLSON FOREST V.A. Cam			23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. CO. MO			
24. FUNERAL DIRECTOR NAME JOSEPH L. RUSS			ADDRESS 2222 W. NORTH AVE			25a. DATE REC'D. BY REGISTRAR APR 16 1986			25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>			

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(VR A15 ME (5))

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00-04334

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10447

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Herbert L. Barth			2a. DATE OF DEATH MONTH DAY YEAR 4 17 86			2b. HOUR 11:00 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 30 23		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Automobile	
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3833 Brooklyn Ave. 21225	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph F. Barth				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Coyne					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II		17. INFORMANT Joseph F. Barth Jr.		17b. ADDRESS Benthicum, Md 21090 412 Linda Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension, lung ca. &amp; metast.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/11/86</u> to <u>4/17/86</u> , that (I) (we) lost saw the deceased alive on <u>4/11/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>W. Vazquez</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Vazquez				22e. ADDRESS South Baltimore General H.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/21/86		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore A.A. Md		
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md					25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

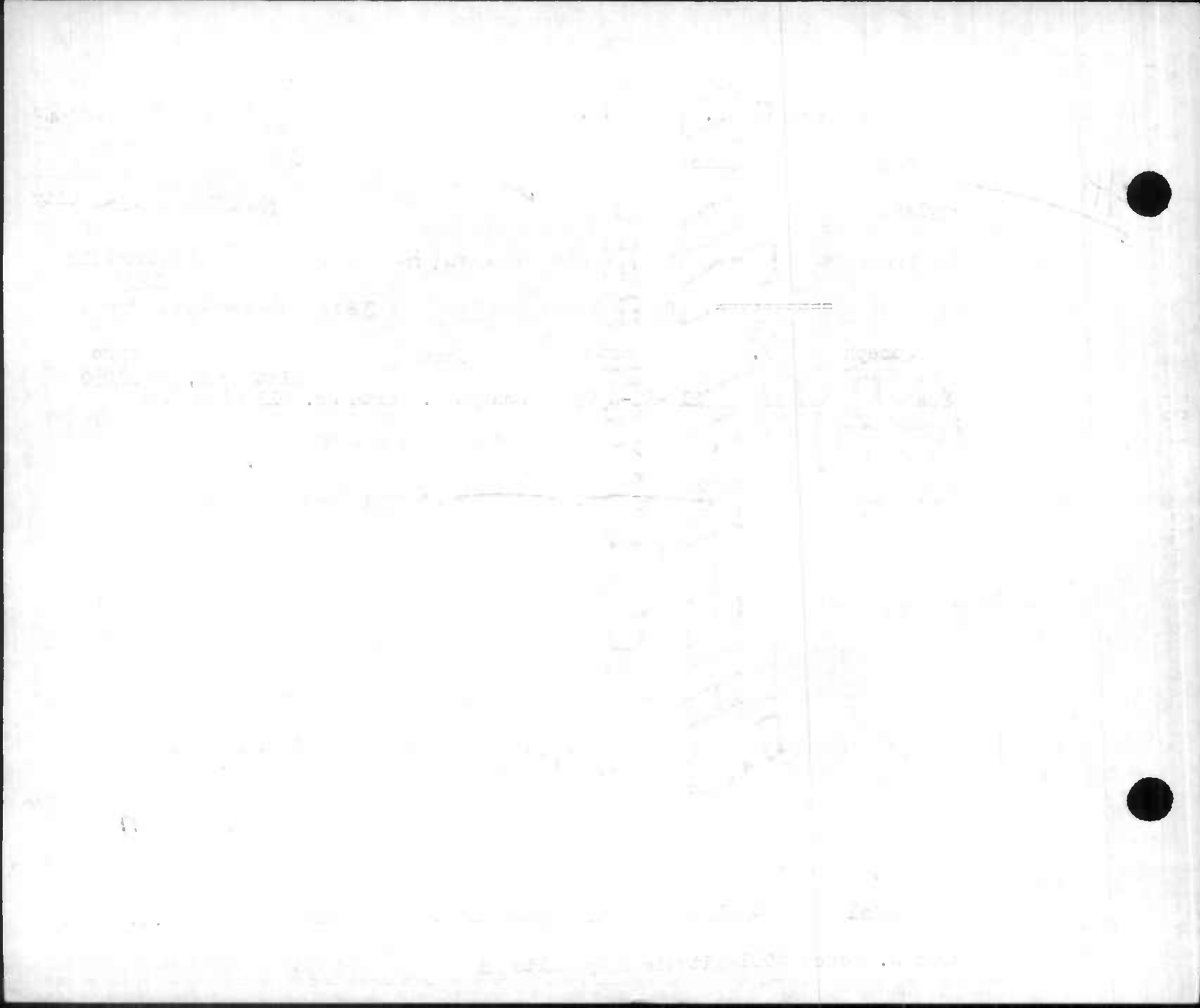
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-02964

DIVISION OF VITAL RECORDS W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

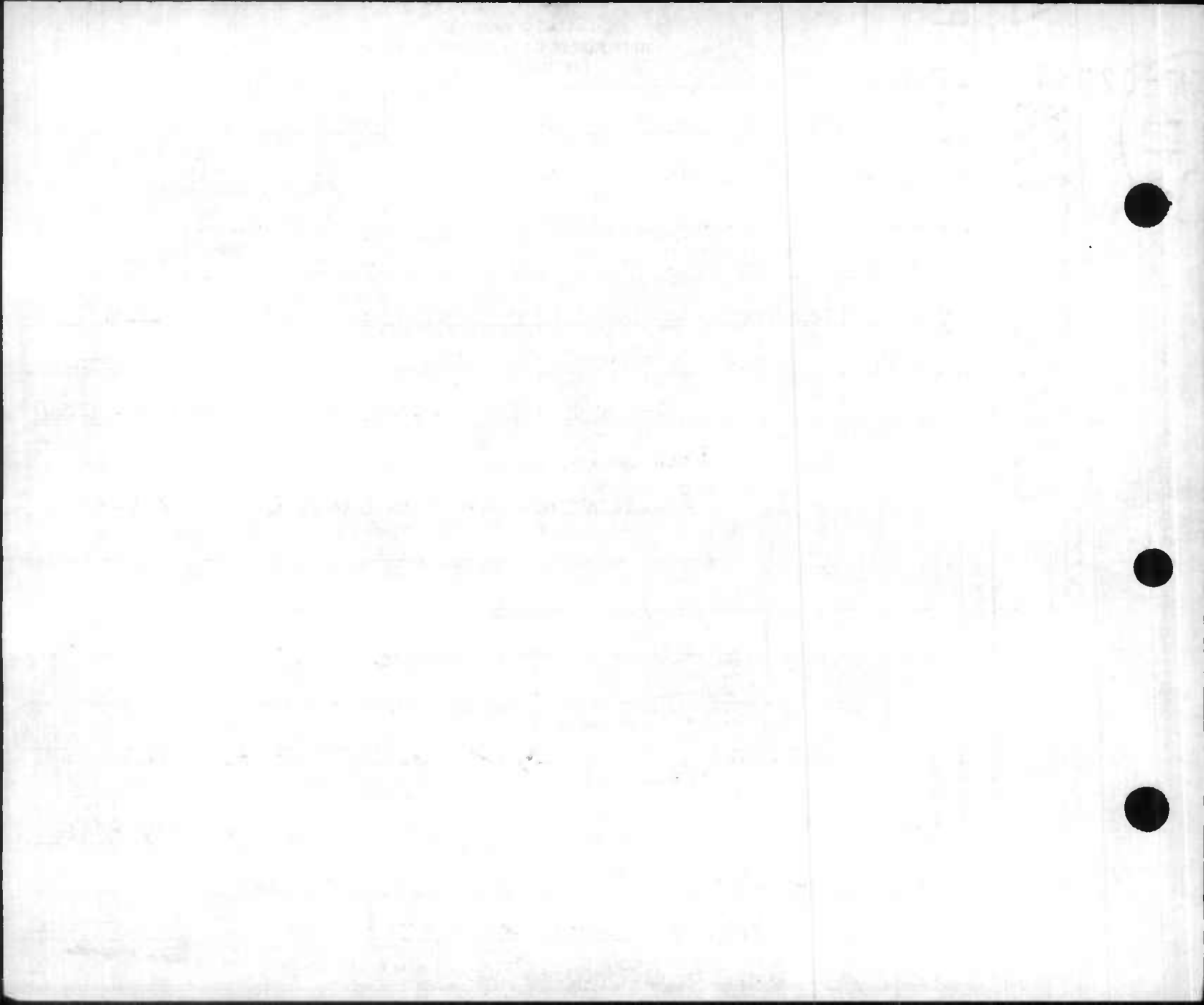
IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, in addition to cause of death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 10448	
1- FOR STATE REGISTRAR DECEASED NAME FIRST MIDDLE LAST DOROTHY E. BATHGATE					2a DATE OF DEATH MONTH DAY YEAR APRIL 7, 1986			2b HOUR 4:32A M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 1 31		6 AGE (IN YEARS (LAST BIRTHDAY)) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.			
7a BIRTHPLACE (COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Psychic		12b. KIND OF BUSINESS OR INDUSTRY Self Emp.			
13a STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1444 Barrett Rd. 21207			
14 FATHER'S NAME FIRST MIDDLE LAST William D. Sellers					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian P. Parker						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-26-8008		17. INFORMANT Nancy E. Bathgate		ADDRESS 1444 Barrett Rd. 21207					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RECURRENT HEAD AND NECK CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 year</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT HOME <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/18</u> , 19 <u>86</u> , to <u>4/7</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>4/7</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Daniel L Clemens, MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4/7/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Daniel L Clemens, MD</u>					22e. ADDRESS <u>Johns Hopkins Hospital</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>4/10/86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Maryland</u>					
24 FUNERAL DIRECTOR NAME ADDRESS <u>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</u>					25a. DATE REC'D. BY REGISTRAR <u>APR 9 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

BP \_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)





00-02619

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10449

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. DATE OF BIRTH		4. AGE (IN YEARS)	
Jack E. Batson		8 10 21 64 YRS.		4 1/ 19 86	
2. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. CITIZEN OF WHAT COUNTRY?	8. MARRIED
Male	White	8 10 21 64 YRS.	4 1/ 19 86	U. S. A.	NEVER MARRIED
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Md.		Baltimore		St. Agnes Hospital	
12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS	
Retired-Self Employed				Balto., Md.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Emmett Batson		Lena Murray		214-12-9431	
17. INFORMANT		18. CAUSE OF DEATH		19. DATE OF OPERATION	
Elizabeth J. Batson		Cerebral Trauma		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
2225 Wilkens Ave. - Balto. Md.		8/20		20. AUTOPSY?	
#21223				HEAD ONLY	
21. PLACE OF INJURY		22. I certify that I took charge of this remains described above, held on		23. NAME OF CEMETERY OR CREMATORY	
subject driver of auto hit parked van		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		Westview Mem. Pk. Cemetery	
500 Blk. S. Bentalou St., Baltimore City, Md.		death resulted from: Natural Causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. FUNERAL DIRECTOR	
		TITLE (SPECIFY)		G. Truman Schwab	
		M.D. Assistant		3512 Frederick Ave.	
		DATE SIGNED 4/1/86		# 21229	
		25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE	
		APR 04 1986		John Davidson	

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (1))

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8610450  
REG. NO.

00-02875

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) TERRY BEASLEY			2a. DATE OF DEATH MONTH DAY YEAR APRIL 6, 1986		2b. HOUR 11:40 A.M.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 24 1964	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 21		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (WORK FOR MOST OF WORKING LIFE) Stock Keyer Food Market		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Md BALTO Balto	13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS / ZIP CODE 5823 Belle View Rd			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Beasley	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marjorie Beasley		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (GIVE WAR OR DATES) YES Reserves		
17a. SOCIAL SECURITY NO.		17b. INFORMANT ADDRESS Marjorie Beasley-5823 Belle View Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) hepatic failure DUE TO, OR AS A CONSEQUENCE OF (c) aplastic anemia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute 3 weeks 4 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a renal failure, convulsions, pneumonia, edema, barium swallow plant					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1986 to April 6, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Matthew R. Wolff		DEGREE		22c. DATE SIGNED 4/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Matthew R. Wolff		22e. ADDRESS 601 N. W. Street Baltimore Md			
23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial	23b. DATE 4-10-86	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md	
24. FUNERAL DIRECTOR NAME Darnell B. Oden-163 R. D. in Hill		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE APR 8 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, return the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

00-00000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8610451  
REG. NO.

1- FOR STATE REGISTRAR

1 DECEASED NAME FIRST MIDDLE LAST  
CARELTON R BEATTY

2a. DATE OF DEATH MONTH DAY YEAR 2b HOUR  
4-5-86 5:48 PM

3 SEX M 4 RACE WHITE 5. DATE OF BIRTH MONTH DAY YEAR  
10 25 06

6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md. 7b CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.

10 CITY OR TOWN OF DEATH BALTIMORE 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security - Retired 12b KIND OF BUSINESS OR INDUSTRY Bendix

13a STATE Md. 13b COUNTY 13c CITY OR TOWN Balto. 13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS / ZIP CODE 3916 Fleetwood Aven-21206

14. FATHER'S NAME FIRST MIDDLE LAST Robert E. Beatty 15 MOTHER'S MAIDEN NAME Agnes Horstman

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b SOCIAL SECURITY NO. 218-10-6032 17 INFORMANT ADDRESS Mrs. Mabel V. Beatty - 3916 Fleetwood Ave. 21206

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) CORONARY ARTERY DISEASE

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☒ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (this hospital) attended the deceased from MARCH 30, 1986, to APRIL 5, 1986, that (we) last saw the deceased alive on APRIL 5, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE Thomas S. Miller DEGREE MD 22c. DATE SIGNED 4/5/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS S. MILLER MD 22e ADDRESS GOOD SAMARITAN HOSPITAL BALT., MD. 21239

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 4-8-86 23c NAME OF CEMETERY OR CREMATORY Moreland Memorial Park Balto. Md. 23d LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206 ADDRESS 25a DATE OF REGISTRATION APR 1 1986 25b REGISTRAR'S SIGNATURE J. Davidson

2000

100%

0-02769

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10452

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gertrude M. Beaudet			2a. DATE OF DEATH April 4, 1986			2b. HOUR 6 a.m.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH Aug. 30, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1622 E. Coldspring Lane			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1622 E. Coldspring Lane 21218	
14. FATHER'S NAME FIRST MIDDLE LAST Paul O. Burkhardt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Paige					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-03-4616		17. INFORMANT ADDRESS Anne M. Griffin 1713 Redwood Ave. 21234				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

Adenocarcinoma of lung

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

6 months

(b)  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) hospice	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (a) (this hospital) attended the deceased from Feb 3 19 86 to April 4 19 86, that (we) lost saw the deceased alive on April 3 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.			
23. SIGNATURE Dr. Worth B. Daniels Jr. M.D.		24. DATE SIGNED 4/4/86	
25. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Worth B. Daniels Jr. M.D.		26. ADDRESS 11 E. Chase Street Baltimore, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Apr 7 1986	23c. NAME OF CEMETERY OR CREMATORY Westview Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland		25. DATE REC'D. BY REGISTRAR APR 7 1986	
26. REGISTRAR'S SIGNATURE		27. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





00-04525

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10453

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES BECHTEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>04 18 86</b>		2b. HOUR P <b>9:00</b>
3. SEX <b>MALE</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>01 11 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b>		10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Simms Hosp of Balt.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>BALT</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH BECHTEL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BARHAM, THERESA</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>215-12-5792</b>		17. INFORMANT ADDRESS <b>ATTENDING</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAINSTEM INFARCT / STROKE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CEREBRO VASCULAR INFARCT</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>IDDM, CHOLELITHIASIS, GOUT, CRF; CARDIAC ARYTHMIAS</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/11/86</b> , 19 <b>86</b> , to <b>4/18</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/18/86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Corpeus</b>		DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VORBERGION</b>		22e. ADDRESS <b>Simms Hosp of Balt.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>4-19-86</b>		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25. DATE RECEIVED BY REGISTRAR <b>APR 24 1986</b>	
		26. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

00-004255

CHIEF

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CHIEF

20%

00-02669

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED NON MED DR. D. SMYTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the medical examiner, or the medical examiner's representative, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

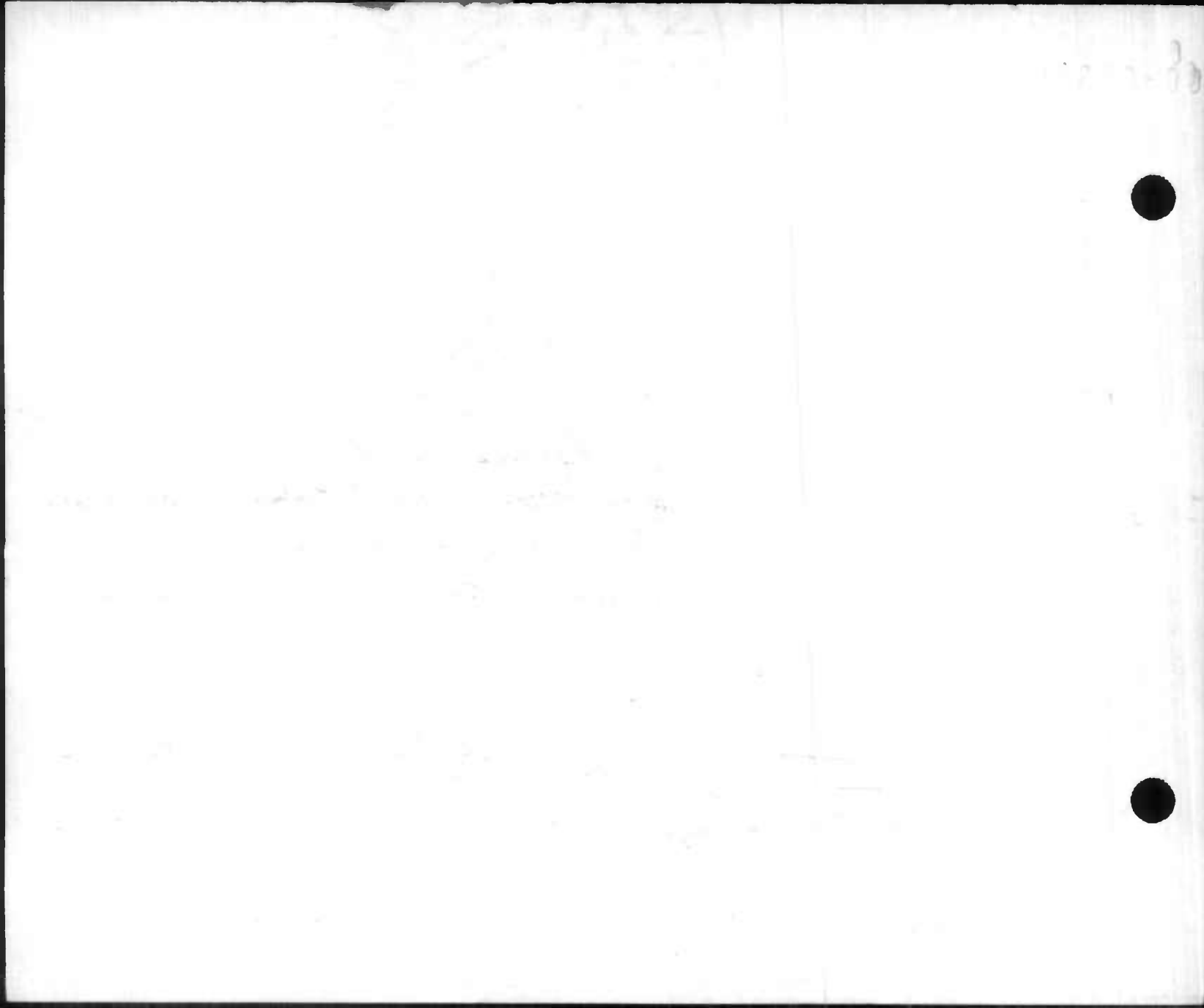
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610454

REG. NO

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		Emily Antoinette Beckwith				april 3, 1986		1:544AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		Caucasian		12-11-1892		93 yrs.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		USA				BALTIMORE CITY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		Housewife		Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Md.				Baltimore				21205 3030 MeElderry Street	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
John Long		Annabelle Kemp		no		214-38-8138		Miss Ruth Beckwith Same Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several years</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Hypertension; Transient Ischemic Attacks; Peripheral Vascular Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>3/8/86</u> to <u>5/24/86</u> , that (I) (we) lost <u>5/24/86</u> saw the deceased alive on <u>3/8/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Albert B. Bradley</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/4/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Albert Bradley		22e. ADDRESS 4900 Belair Road							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		4-7-86		Baltimore Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR Schamunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213		25a. DATE REC'D. BY REGISTRAR APR 04 1986		25b. REGISTRAR'S SIGNATURE					

BP



00-04786

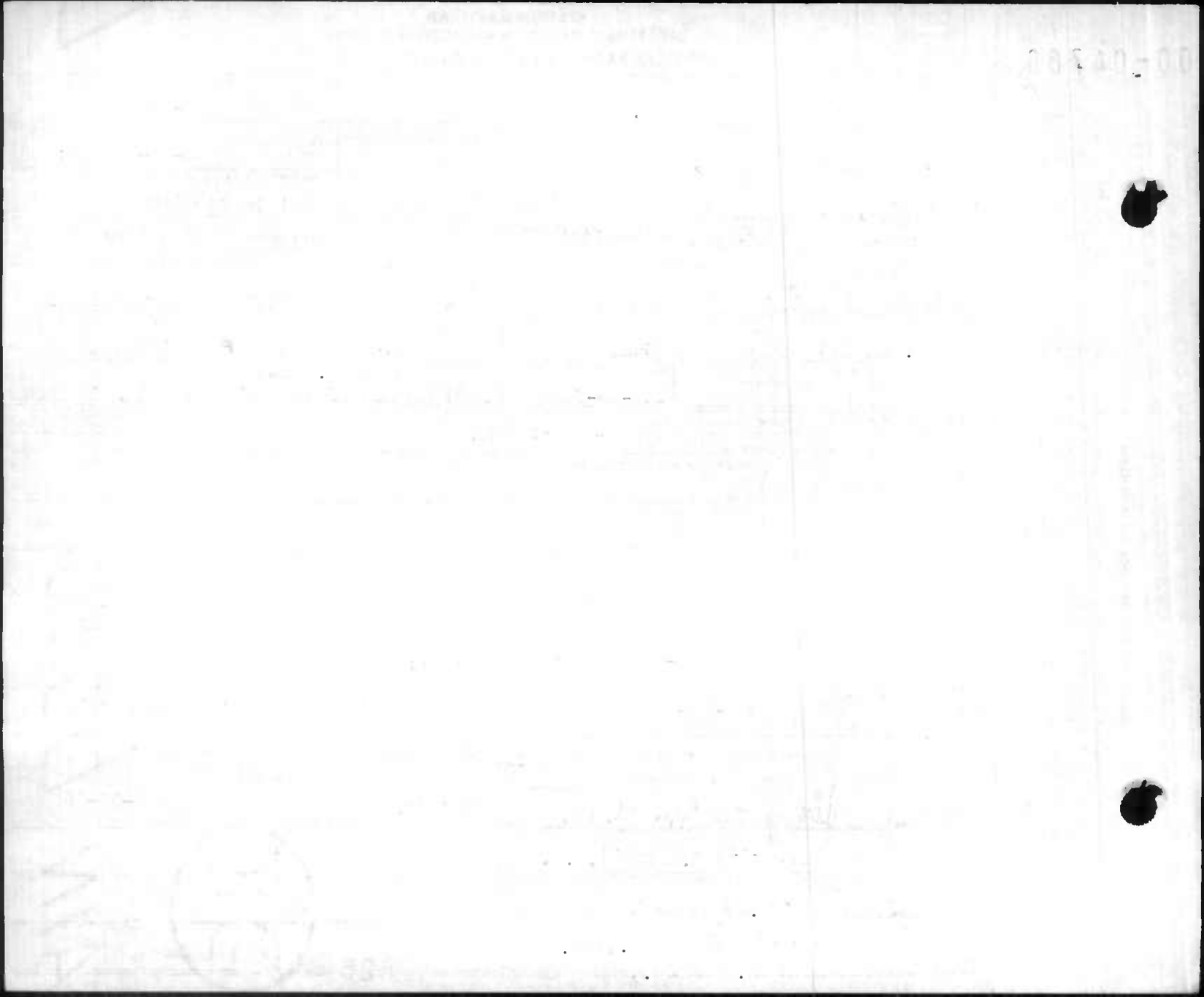
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

FOR STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10455				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SUSAN E. BELL										2a. DATE KNOWN OF DEATH MONTH DAY YEAR XX 4-21-86					2b. HOUR OF DEATH M 2:20A									
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 1, 1953		6. AGE (IN YEARS) (LAST BIRTHDAY) 32 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4-21-86					2d. HOUR M 2:20A							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.												
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION University Hospital STU						12a. USUAL OCCUPATION (TYPE OF WORK) HOUSEWIFE					12b. KIND OF BUSINESS AT HOME									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY HOWARD 13c. CITY OR TOWN COLUMBIA										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS 9204 BROKEN TIMBER WAY 21045									
14. FATHER'S NAME FIRST MIDDLE LAST DR. IRVING AVRO WOODS										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSALIND LOUISE SPIELMAN														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 220-48-9630				17. INFORMANT JOHN D. BELLE ADDRESS 9204 BROKEN TIMBER WAY COLUMBIA, MD 21045																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. HEAD ONLY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. 4:20 P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) self/inflicted														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home					21f. LOCATION 9204 Broken Timberway, Columbia, Maryland														
22a. I certify that I took charge of the remains described (HEAD ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																								
ACTUAL SIGNATURE Margarita A. Korell, M.D.					TITLE (SPECIFY) Assistant					DATE SIGNED 4-21-86														
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.					ADDRESS 111 Penn Street																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION					23b. DATE APR. 23, 1986					23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK					23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND									
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.										25a. DATE REC'D. BY REGISTRAR APR 25 1986					25b. REGISTRAR'S SIGNATURE									
6010 REISTERSTOWN RD. BALTO., MD 21215																								



00-04606

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10456

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIE BELLAMY			2a. DATE OF DEATH MONTH DAY YEAR 04 21 86		2b. HOUR 1239 PM
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 09 11 10		6. AGE (IN YEARS LAST BIRTHDAY) 75 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 329 Stinson Street 21223	
14. FATHER'S NAME FIRST MIDDLE LAST John Perkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Hilbert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 24474-135		17. INFORMANT ADDRESS Curtis Bellamy 2579 W. Fayette Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Spontaneous Tension Pneumothorax and Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Uncontrolled Seizure Disorder</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES HOURS TO 1 day 2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Acute Congestive Heart Failure; Diabetes Mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 19 71</u> to <u>4-21 1986</u> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>4-21 1986</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> not view the body after death.					
22b. SIGNATURE <u>William R. Law</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-21-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM R. LAW, M.D.		22e. ADDRESS BON SECOURS HOSPITAL 2000 W. BALTIMORE ST. BALTO. MD 21223			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/26/86	23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD
24. FUNERAL DIRECTOR NAME William C. March F/H West			ADDRESS 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR APR 24 1986
					25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked on any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610457  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL APRIL N. BELT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 21, 1986</b>		2b. HOUR <b>1:15 P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 20 1986</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>BALTIMORE CITY OR COUNTY OF DEATH</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JEFFERY BELT</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>TINA NICKERSON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		
16b. SOCIAL SECURITY NO.		17. INFORMANT <b>JEFFERY BELT 1776 Belle Drive</b>		ADDRESS <b>Annapolis, Md. 21401</b>		

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypoxia, hypercarbia, acidosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pulmonary hypoplasia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>renal hypoplasia (Potter's Syndrome)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 hour</b> <b>16 hours</b> <b>16 hours</b>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------------------------------------------------------

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9 pm 4/20 19 86</u> to <u>1:15 PM 4/21 19 86</u> , that (I) (we) last saw the deceased alive on <u>1:15 PM 4/20 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Joe Kaempff</u>				22c. DATE SIGNED <u>4/21/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KAEMPF</u>				22e. ADDRESS <u>Johns Hopkins Hospital</u>	

23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>4-24-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILL CREST CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNAPOLIS A.A. MARYLAND</b>		24. FUNERAL DIRECTOR <b>Annapolis, Md. 21401</b> <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>			
25a. DATE REC'D. BY REGISTRAR <b>APR 25 1986</b>		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

700910-1

UNITED STATES DEPARTMENT OF THE ARMY

HEADQUARTERS, 10th Army, Fort Belvoir, Colorado

10-10-50



10-10-50

10-10-50

10-10-50

00-044

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10458  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANDREW J. BERAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 22, 1986</b>		2b. HOUR <b>2:42A M</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 13, 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>	
13a. STATE <b>MD.</b>		13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES W. BERAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JEANETTE L. WITTIG</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>212-22-7859</b>		17. INFORMANT ADDRESS <b>Ms Catherine S. Pitty - 6810 Banks St. 21224</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>60 MINUTES</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CORONARY ARTERY disease</b> <b>25 YEARS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROTIC HEART disease</b> <b>25 YEARS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>0</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 19 68</b> , to <b>APRIL 22, 19 86</b> , that (I) (we) last saw the deceased alive on <b>4/22</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Hyam I. Levitsky</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4/22/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HYAM I. LEVITSKY</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>APR. 25, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>	
24. FUNERAL DIRECTOR NAME <b>HARTZLEY MILLER FUNERAL HOME</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 23 1986</b>		
ADDRESS <b>2334 JEFFERSON ST.</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Swindler</b>		

RELEASED AS NON-MED PER MR. FREEMAN &amp; DR. KAUFFMAN MEDICAL EXAMINER'S

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please forward to the coroner's office. Page 4 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene (or to burial, cremation, or removal). IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-11-01

12-30-SET 8

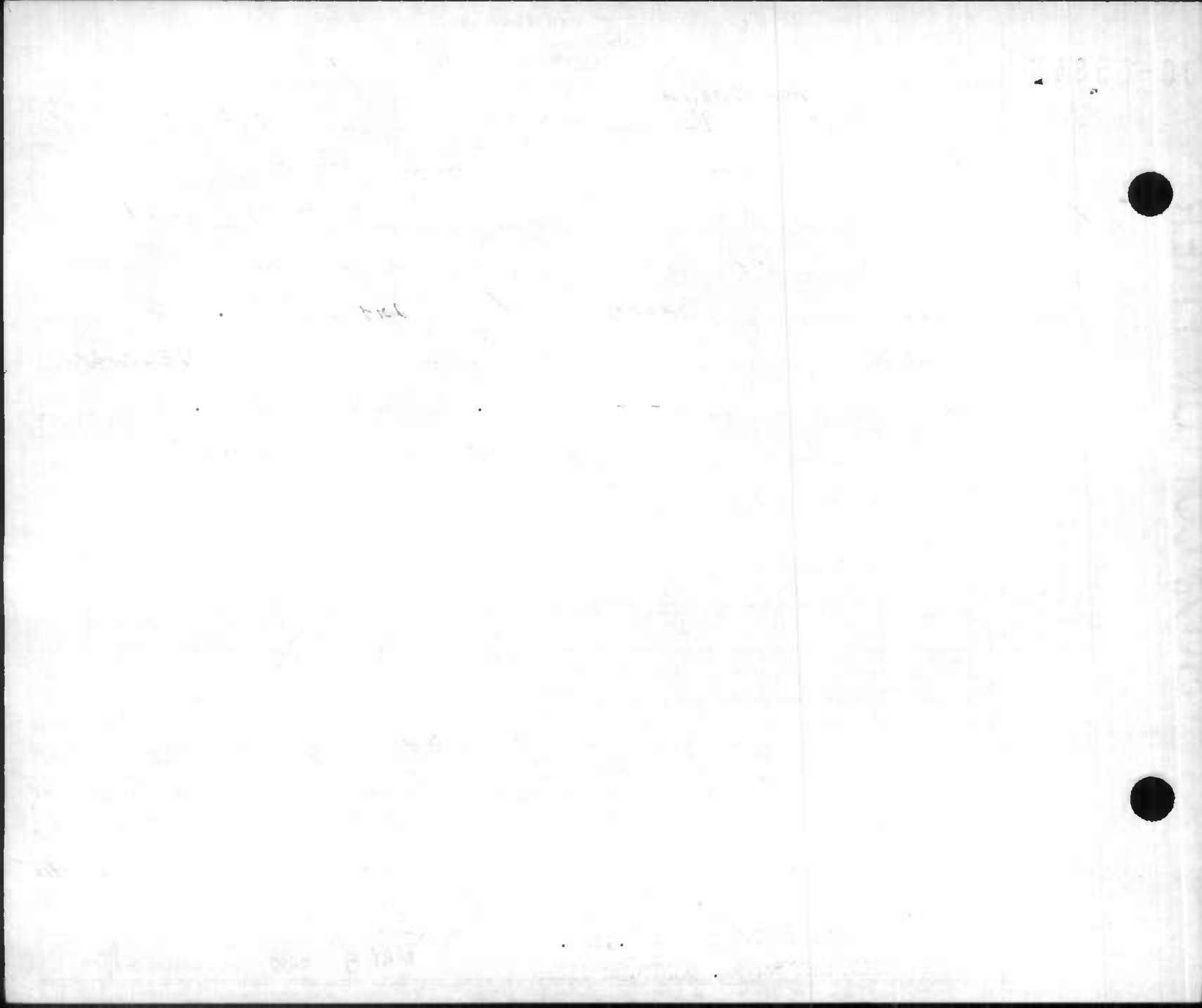
00-05646

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove surplus papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 10459	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Ruth</i> AKA <i>REBECCA</i> MIDDLE <i>R</i> LAST <i>Berger</i>		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
				4/30/86				9 30 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			
Female		WHITE		7 4 XXXXX		XX8 79 YRS		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.				BALTO MD 21205 MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Balto Md		Levindale		HOUSEWIFE		AT HOME					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
MARYLAND				BALTO.		13e. STREET ADDRESS / ZIP CODE					
						2019 WILKENS AVE. 21223					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)							
FIRST MIDDLE LAST		FIRST MIDDLE LAST		16b. SOCIAL SECURITY NO.							
LOUIS		BERGER		218-05-6459							
				17. INFORMANT ADDRESS							
				MR LOUIS BERGER 6 SAXONY CT. 21208							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a)		Bilateral PNEUMONIA, recurrent									
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)									
DUE TO, OR AS A CONSEQUENCE OF		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2-13 86, 19 86, to 4-30 86, that (I) (we) last saw the deceased alive on 4-30 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
<i>[Signature]</i>				5-1-86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR							
B-2AN-WIN		Levindale Geriatric GR BALTO MD 21205		MAY 6 1986							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. MARYLAND STATE			
BURIAL		5/2/86		MOSES MONTEFIORE CEM		BALTIMORE					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS		MAY 6 1986				<i>[Signature]</i>					
6010 REISTERSTOWN RD. BALTO, MD 21215											



00-03591

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 4 6 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DR. Thomas Alan Berman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 9 86</b>		2b. HOUR <b>9:30 a</b> M
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 2 50</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>35</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DENTIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DENTISTRY</b>
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3301 RED SPIRE LA. #21208</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DR. DANIEL E. BERMAN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SALLY ESTHER BOYETTE</b>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-48-9158</b>	17. INFORMANT <b>MRS. DEBRA BERMAN</b> <b>3301 RED SPIRE LA. BALTO., MD 21208</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory &amp; cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart Failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sep 1985</u> to <u>4/9</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/9</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/9/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Luis M. Zuni 62</u>		22e. ADDRESS <u>900 S. CATON AVENUE BALTO., MD 21229</u> <u>1101 maiden choice lane Balt 21229</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>APR. 11, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OHEB SHALOM MEM. PARK</b>		23d. LOCATION <b>REISTERSTOWN BALTO. MD</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS. INC.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 15 1986</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
6010 REISTERSTOWN RD. BALTO., MD 21215					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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YIP HUI TAI

DATE - 22.02.73

TIME

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APR 7 1973



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8610461  
REG. NO.

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Howard H Berneau		2a. DATE OF DEATH MONTH DAY YEAR April 21, 1986		2b. HOUR 5 <sup>25</sup> P.M.	
3 SEX m		4 RACE b		5. DATE OF BIRTH MONTH DAY YEAR 6 24 24		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? u.s.a.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/a		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNK.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK.		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-74-7281	
17. INFORMANT Fred Jeter		ADDRESS 1312 Clifton St. Wash. D.C.		20009			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous Cancer head/neck</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>malnutrition</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 42 86 42c 19 86			
22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>4/14</u> 19 <u>86</u> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>we</del> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>J.P. Gladue, MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/21/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-27-86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundale County	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR APR 25 1986			
				25b. REGISTRAR'S SIGNATURE			

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00-02881

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

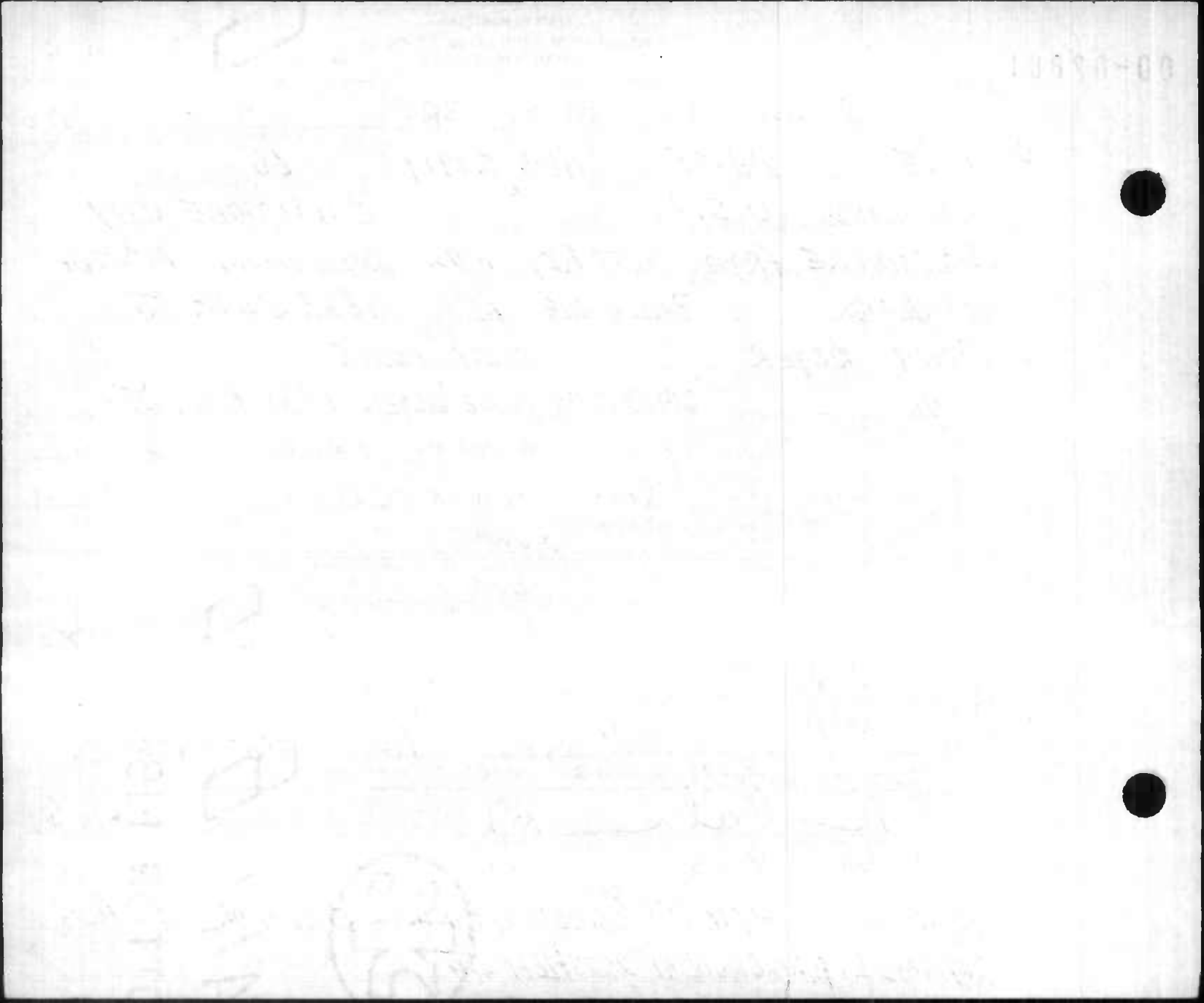
DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610462

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John H. BEYER SR.			2a. DATE OF DEATH MONTH DAY YEAR 4 6 86		2b. HOUR 158 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV. 2 1919	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY M.Q.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR	12b. KIND OF BUSINESS OR INDUSTRY MARTIN	
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS - ZIP CODE 1828 BANK ST. 21231	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BEYER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY PUNTE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214032054	17. INFORMANT ADDRESS ROSE BEYER 1828 BANK ST.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>					
19a. DATE OF OPERATION <u>N/A</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <u>N/A</u>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>N/A</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N/A</u>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> <u>N/A</u>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>	21f. LOCATION STREET <u>N/A</u>	CITY OR TOWN	COUNTY	STATE
22a. I certify that (i) (this hospital) attended the deceased from <u>4/6/86</u> to <u>4/6/86</u> , that (ii) (we) lost saw the deceased alive on <u>4/6/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 4/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STUART KATZ		22e. ADDRESS 4440 Eastern Ave BALTO 21224			
23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL	23b. DATE 4/10/86	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITHS	23d. LOCATION CITY OR TOWN BALTIMORE	COUNTY	STATE
24. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI		25a. DATE REC'D. BY REGISTRAR APR 08 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



00-03688

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10463  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Richard Louis Birch			2a. DATE OF DEATH MONTH DAY YEAR April 14, 1986			2b. HOUR 2:15 a.m.				
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01-17-20		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gas Construction		12b. KIND OF BUSINESS OR INDUSTRY BG & E		
13a. STATE Maryland			13b. COUNTY A.A. Co.		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 324 Cheddingham Rd. 21090	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Birch			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Tucker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 218-10-9489		17. INFORMANT ADDRESS Lillian G. Birch Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Hardening</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1963</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Previous Arterial &amp; Venous Infections &amp; Rt. Branch Branch 3/86</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-22-86</u> , 19 <u>86</u> , to <u>3/27/86</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>3-22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Lester Leibo MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4/14/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LESTER LEIBO MD</u>			22e. ADDRESS <u>3001 S. HANOVER ST 21230</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-17-86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD		
24. FUNERAL DIRECTOR NAME McCully Funeral Home, 237 E. Patapsco Ave			BALTO. MD. 21225			25a. DATE REC'D. BY REGISTRAR APR 15 1986			25b. REGISTRAR'S SIGNATURE <u>J. H. Anderson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

10-00000

APR 15 1908

0-05369

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

FOR  
1- STATE  
REGISTERSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 4 6 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Inez Blackstone</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4/28/86</b>				2b. HOUR <b>6:45 P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 24 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore CITY MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LAUNDRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FISH LAUNDRY</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2305 BRADDISH AVE BALTIMORE, MARYLAND 21216</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES HATCH</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CORA PRICE</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>					
16b. SOCIAL SECURITY NO <b>217-22-5694</b>		17. INFORMANT <b>ROGER BLACKSTONE</b>				18. ADDRESS <b>2305 Braddish Avenue Baltimore, Maryland 21216</b>			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brainstem herniation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral Vascular Accident</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>HTN</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/28</b> , 19 <b>86</b> to <b>4/28</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/28</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Eleanor V. Hixon, MD</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/28/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eleanor V. Hixon, MD</b>				22e. ADDRESS <b>3100 Towanda Ave Belt. 21215</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>ENTOMBMENT</b>		23b. DATE <b>5/3/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR <b>NOTER &amp; SONS FUNERAL HOME, INC.</b>	
25a. DATE REC'D. BY REGISTRAR <b>MAY 1 1986</b>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

BP

00000

DATE  
10/11/00





00-05728

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and not completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10463  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Royal BLAND</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 24, 1986</b>		2b. HOUR MIN <b>11:19 A</b>						
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 20 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89 yrs</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2027 Madison Ave. 21217</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sarah Dupee</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Dupee</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-05-1133</b>		17. INFORMATION ADDRESS <b>Medical Records Dept. 21201</b> <b>Maryland General Hospital 827 Linden Ave.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <b>887</b> IMMEDIATE CAUSE (a) <b>Probable Myocardial infarction</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>right hip fracture ; Cerebrovascular accident; history of Myocardial Infarction</b>											
19a. DATE OF OPERATION <b>Apr. 3, 16, 86</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture of right hip</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION APPROVED BY MEDICAL EXAMINER CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>March 25</b> 19 <b>86</b> , to <b>April 24</b> 19 <b>86</b> , that (we) last saw the deceased alive on <b>April 24</b> 19 <b>86</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Timothy Low</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/24/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Timothy Low, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>4-28-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HHQHBBHII</b>		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 05 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-020576

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
*Stella B Bogdan*

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
*4 1 86 8:35 PM*

3. SEX *Female* 4. RACE *White* 5. DATE OF BIRTH MONTH DAY YEAR  
*January 17 1903*

6. AGE (IN YEARS LAST BIRTHDAY) 7. CITIZEN OF WHAT COUNTRY? 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐  
*83 USA*

9. BALTIMORE CITY OR COUNTY OF DEATH *Baltimore City MD*

10. CITY OR TOWN OF DEATH *Towson* 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
*Stella Maris Hospice*

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY  
*Housewife*

13a. STATE *Md.* 13b. COUNTY *Harford* 13c. CITY OR TOWN *Joppa* 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ 13e. STREET ADDRESS / ZIP CODE  
*2611 Franklinville Rd. 21085*

14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
*Alexander Gosa Maryann Unknown*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS  
*No 213-05-8996 William A. Bogdan 2611 Franklinville Rd.*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) *Metastatic Adenocarcinoma of the colon*  
DUE TO, OR AS A CONSEQUENCE OF (b)  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
*P.M. 19* 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  
*March 31 1986 to April 1 1986*

22a. I certify that (I) (this hospital) attended the deceased from *March 31 1986* to *April 1 1986* that (I) (we) rest saw the deceased alive on *March 31 1986*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE *Kendall Faulkner M.D.* DEGREE 22c. DATE SIGNED  
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS  
*Kendall Faulkner, M.D. 2300 Dulaney Valley Rd. - Towson, MD 21204*

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) *Burial* 23b. DATE *4-5-1986* 23c. NAME OF CEMETERY OR CREMATORY *Holy Rosary Cemetery* 23d. LOCATION CITY OR TOWN COUNTY STATE  
*Baltimore Md*

24. FUNERAL DIRECTOR NAME *John M. Weber & Sons Inc. 401 S, Chester St.* 25a. DATE REC'D. BY REGISTRAR *APR 4 1986* 25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

USA



CO. 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 10467

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST FLORENCE	MIDDLE	LAST BOGGESS	2a DATE OF DEATH MONTH DAY YEAR 4/17/86		2b HOUR 2 02 P M	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 26 99			6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 73 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10 CITY OR TOWN OF DEATH CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY		

13a STATE Md.		13b COUNTY	13c CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 116 W. Univ. Pkwy. 21210	
14 FATHER'S NAME FIRST MIDDLE LAST David Kline			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 050-28-9563		17 INFORMANT 3731 ADDRESS Washington Ave. Ms. Mildred Gertman Balto., Md.		

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

cardiac arrest and respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

chronic renal failure-end stage

DUE TO, OR AS A CONSEQUENCE OF

(c)

myocardial infarction

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110

Anemia, possible infarcted bowel

19a DATE OF OPERATION Ø	19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ø	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 4/17 19 86 to 4/17 19 86, that (I) (we) last saw the deceased alive on 4/17 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated			
22b SIGNATURE <i>Lisa R. Battle</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c DATE SIGNED 4/17/86
22d PHYSICIAN'S NAME (TYPE OR PRINT) LISA R. BATTLE		22e ADDRESS UNION MEMORIAL HOSPITAL	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b DATE 4-17-86	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
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24 FUNERAL DIRECTOR NAME Anatomy Board	ADDRESS Balto., Md.	25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>
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APR 24 1986

ADRIAN NOTION BOOK

ADRIAN NOTION BOOK



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10468  
REG. NO.FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William J. Bolek</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 10, 1986</b>		2b. HOUR M <b>AM</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 21 98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3709 Seventh St. 21225</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Md.</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3709 Seventh St. 21225</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Bolek</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Theresa Turek</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216 01 4787A</b>		17. INFORMANT ADDRESS <b>Sister Mary Dolores Same as 13e</b>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Week</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral deep vein obstruction</b>		<b>3 months</b>
DUE TO, OR AS A CONSEQUENCE OF (c)		

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 61</b> to <b>April 86</b> , that (I) (we) last saw the deceased alive on <b>4/8/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Karl F. Melch, Sr., M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4/10/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KARL F. MELCH SR. M.D.</b>				22e. ADDRESS <b>3350 WILKENS AVE</b>		22f. CITY OR TOWN <b>21229</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/14/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn Pk., A.A. Co., Maryland</b>	
24. FUNERAL DIRECTOR <b>George J. Gonce, 4001 Ritchie Hg., Baltimore, MD (21225)</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 16 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John E. ...</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10469  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PEARL BOLDEN			2a. DATE OF DEATH MONTH DAY YEAR APRIL 12 1986		2b. HOUR 4:07AM
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 6 27 01	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SETON HILL MANOR NURSING HM.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 201 NORTH BROADWAY 21231	
14. FATHER'S NAME WILLIAM	MIDDLE GREEN	15. MOTHER'S MAIDEN NAME FRANCES CURRIE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (S. NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. 217-18 9142	17. INFORMANT ADDRESS GERALDINE WEBB 201 N. BROADWAY APT. 19A			
18. CAUSE OF DEATH (Enter only one cause and PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>XXXXXXXXXXXXXXXXXXXX</del> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) UREMIA DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) CIRRHOSIS					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I (this hospital) attended the deceased from MARCH 20, 1986, to APRIL 12, 1986, that I (we) post saw the deceased alive on above (b) (we) (did) did not view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) G. HRUH M.D.		22c. ADDRESS CHURCH HOSPITAL CORP. 100 N. BROADWAY BALTO. MD 21231	22d. DATE SIGNED 4/11/86		
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 4-16-86	23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION	23d. LOCATION CITY OR TOWN COUNTY STATE LANSDOWNE MARLAND	25a. DATE REC'D. BY REGISTRAR APR 15 1986	
24. FUNERAL DIRECTOR WM.C. March		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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00-83764

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

10470

1. DECEASED NAME (TYPE OR PRINT) <b>Helen V Bonhs</b>			2a. DATE OF DEATH MONTH <b>4</b> DAY <b>13</b> YEAR <b>86</b>		2b. HOUR <b>9:10</b> <small>AM</small>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>7</b> DAY <b>19</b> YEAR <b>07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>	
13a. USUAL RESIDENCE (IF MULTIPLE HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 10. STATE <b>Md.</b> COUNTY <b>Baltimore</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Michael</b> MIDDLE <b>AEL</b> LAST <b>DEMBECK</b>		15. MOTHER'S MAIDEN NAME FIRST <b>CASMIRA</b> MIDDLE <b>?</b> LAST <b>?</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cross Blackwell</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-22-0463</b>		17. INFORMANT <b>LORETTA WATHEEN</b>	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anemobacteraemia</b>		DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myelodysplastic Syndrome</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>March 27 1986</b> to <b>April 13 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Russell R. Deluca</b> DEGREE		22c. DATE SIGNED <b>4/13/86</b>	
23a. BURIAL, CREMATION, REMOVAL (IMPRECISE) <b>BURIAL</b>		23b. DATE <b>4-16-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DAK LAWN</b>	
24. FUNERAL DIRECTOR NAME <b>WAITER DABROWSKI</b>		ADDRESS <b>1005 DUNDALK AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 16 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

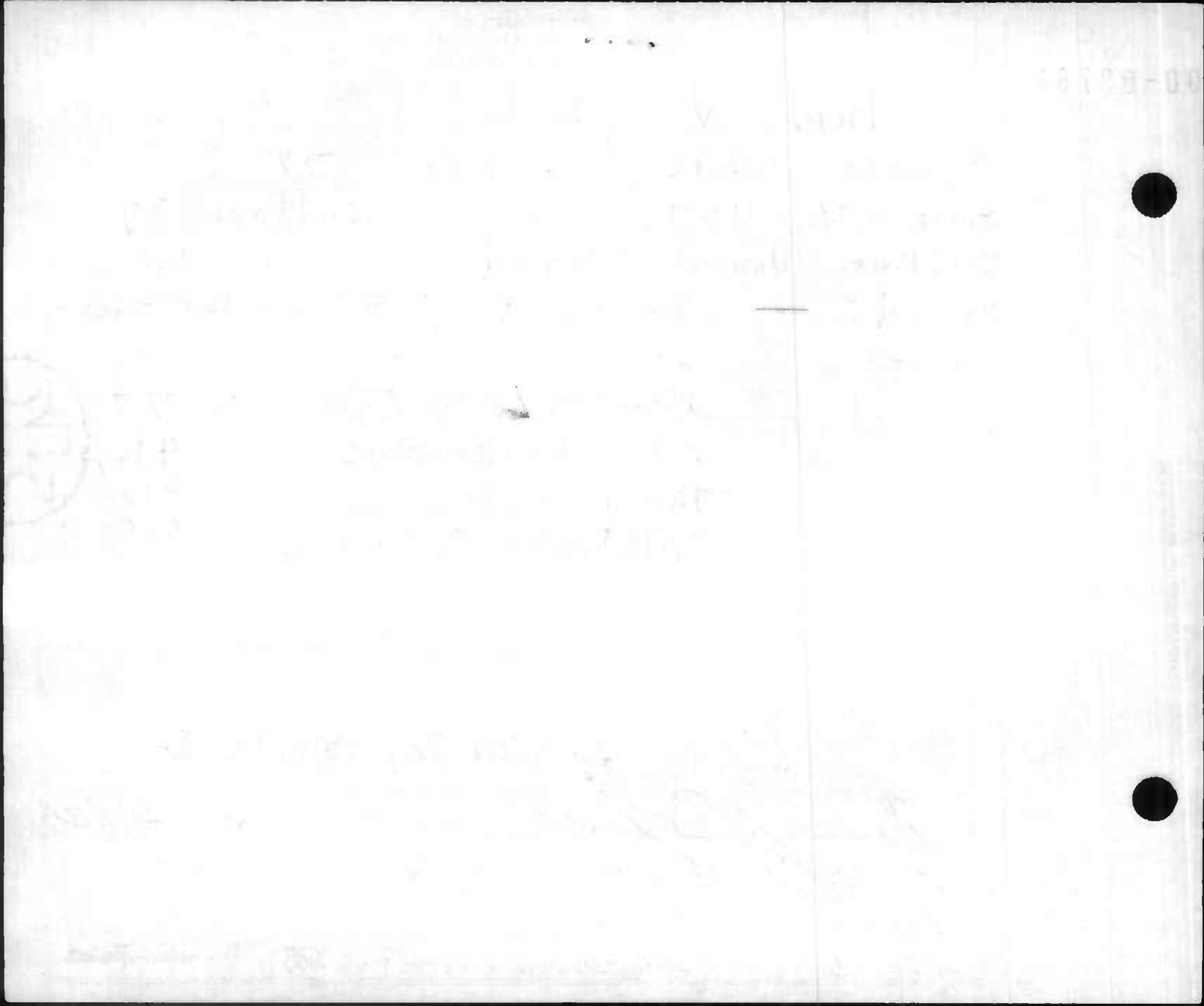
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anemobacteraemia</b>		<b>4 months</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myelodysplastic Syndrome</b>		<b>4+ Months</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 27 1986</b> to <b>April 13 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Russell R. Deluca</b> DEGREE		22c. DATE SIGNED <b>4/13/86</b>			
23a. BURIAL, CREMATION, REMOVAL (IMPRECISE) <b>BURIAL</b>		23b. DATE <b>4-16-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DAK LAWN</b>			
24. FUNERAL DIRECTOR NAME <b>WAITER DABROWSKI</b>		ADDRESS <b>1005 DUNDALK AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 16 1986</b>			
25b. REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE			

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)



00-02924

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

10471

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles M. Booker			2a. DATE OF DEATH MONTH DAY YEAR 4 4 86		2b. HOUR M
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3 26 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4908 St. Georges Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md.			13b. COUNTY n/a	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Ellis Booker, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pattie West		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no n/a		16b. SOCIAL SECURITY NO. 216-07-7789		17. INFORMANT ADDRESS Mamie G. Booker 21212 4908 St. Georges Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Hypertension secondary to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>UNDIFFERENTIATED large cell carcinoma LEFT LUNG</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 6 Wks Months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER</u> 19 <u>86</u> to <u>1 APRIL</u> 19 <u>86</u> that (I) (we) lost saw the deceased alive on <u>16 MARCH</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John F. Rogers</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/6/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN F. ROGERS MD</u>		22e. ADDRESS <u>5601 LOCH RIVEN BLVD</u> <u>GOOD SAMARITAN HOSPITAL</u> BALTO, MD 21239			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/8/86	23c. NAME OF CEMETERY OR CREMATORY King Mem. Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Leroy O. Dyett		ADDRESS 4600 Lib. Hghts. Ave.		25a. DATE REC'D. BY REGISTRAR APR 8 1986	
		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



00-03777

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

10472

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Patricia C Booth</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 5, 1986</b>		2b. HOUR <b>330 AM</b>
3. SEX <b>Female</b>	4. RACE <b>Col 2</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 13 1957</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>28</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1818 Clifton Ave</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Sterling</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Della Green</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-728512</b>		17. INFORMANT ADDRESS <b>Bertha Bryant 2018 N. Fulton Av.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTES</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) <b>FEMORAL VEIN THROMBOSIS</b> <b>2 MONTHS</b>
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SICKLE CELL ANEMIA; RECENT PREGNANCY (~2 MONTHS)</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>1976</b> , 19____, to <b>4/3/86</b> , 19____, that (I) (we) lost saw the deceased alive on <b>4/3/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22a. SIGNATURE <b>Samuel Charache MD</b>		DEGREE		22c. DATE SIGNED <b>4/5/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAMUEL CHARACHE</b>		22e. ADDRESS <b>Johns Hopkins Hospital, Baltimore MD</b>			
23a. BURIAL, CREMATION, REMOVAL (CITY) <b>BURIAL</b>		23b. DATE <b>4-10-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest L.C. Co.</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Baltimore City Md.</b>
24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b>		ADDRESS <b>2222 W. North Ave</b>		25. DATE REC'D. BY REGISTRAR <b>APR 16 1986</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7A4



00-04910

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

10473

1. DECEASED NAME (TYPE OR PRINT) <b>Melvin J. Borkowski</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 23 86</b>			2b. HOUR <b>9:43 a.m.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 1 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver-Bowman Transportation</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John S. Borkowski</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary J. Klonowska</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW II</b>			
16b. SOCIAL SECURITY NO. <b>218-22-8335</b>		17. INFORMANT <b>Melvin R. Borkowski</b>		17. ADDRESS <b>Same as 13c</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>metastatic lung cancer</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Atherosclerosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>D. Mutassem</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4.23.86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Piyaa Moatassem</b>		22e. ADDRESS <b>65H</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/26/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>		ADDRESS <b>7922 Wise Avenue Dundalk, Maryland 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 28 1986</b>			

BP

01930-00

SECRET COLLECTION LIBRARY

CRIMINAL RECORDS





2025 RELEASE UNDER E.O. 14176

00-02700

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

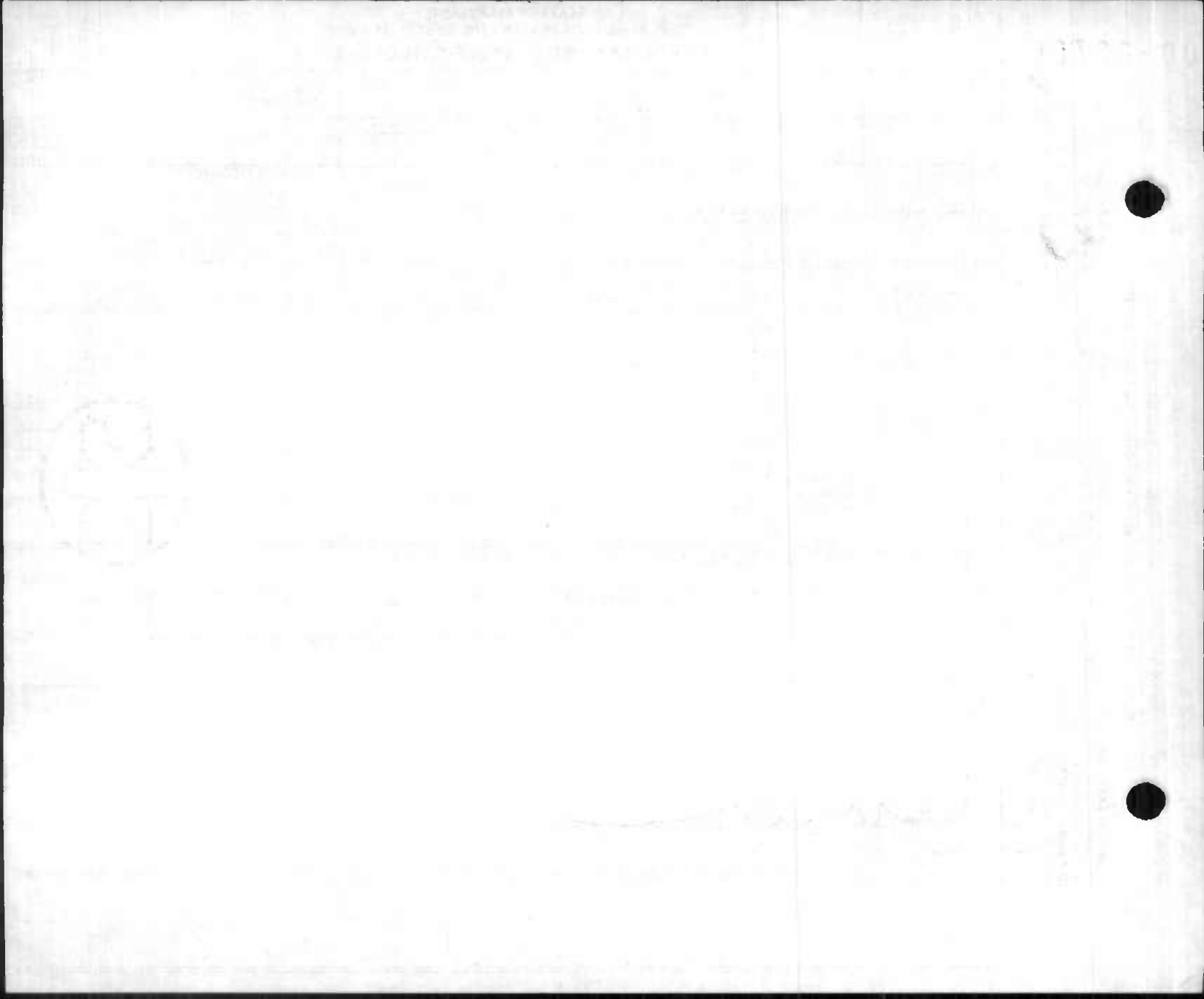
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10474	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FREDERICK E. BOUCHAT</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>4 3 19 86</b>			2b. HOUR M <b>11:57 P</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 2 44</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>42 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN <b>0 0</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4 3 19 86</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>616 Scott St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Punch Press Oper.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>			
13a. STATE <b>Maryland</b>						13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>616 Scott Street</b>						13f. CITY OR TOWN <b>21230</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick C. Bouchat</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Otty</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>215-40-6872</b>		17. INFORMANT ADDRESS <b>Frederick C. Bouchat 1207 N. Cambria St. 16617</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cirrhosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER			DATE SIGNED <b>4-4-86</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>						ADDRESS <b>111 Penn St., Balto., MD 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4/8/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Logan Valley Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bellwood Blair Pa.</b>			
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>				ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 11 1986</b>		25b. REGISTRAR'S SIGNATURE 			

07-84  
25M

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DHMH - 17  
(VR A15 ME (5))



00-04277

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 10 DAYS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. FIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0475	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Coretha</b>					FIRST <b>Bowe</b>					2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>3</b> DAY <b>27</b> YEAR <b>1986</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>7</b> YEAR <b>1913</b>		6. AGE IN YEARS (LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YR. MONTHS <b>72</b> DAYS <b>72</b>		2b. DATE OF DEATH <input type="checkbox"/> MONTH <b>3</b> DAY <b>27</b> YEAR <b>1986</b>	
7a. BIRTHPLACE (STATE OR COUNTY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1338 W. Mosher Street</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CUSTODIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>U.S.A.</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14. FATHER'S NAME <b>JOHN</b> MIDDLE <b>HILL</b> LAST <b>THOMAS</b>			15. MOTHER'S MAIDEN NAME <b>SARAH</b> FIRST <b>THOMAS</b> MIDDLE <b>THOMAS</b> LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-20-5129</b>		
17. INFORMANT <b>HELEN MAE WHITE</b>			ADDRESS <b>1338 W. MOSHER ST. 21217</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease &amp; Cachexia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>3/27/86</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 PennSt. Balto.MD.</b>							
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>				23b. DATE <b>4-1-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CROWNSVILLE VETERAN</b>				23d. LOCATION CITY OR TOWN <b>CROWNSVILLE</b> COUNTY <b>M.D.</b> STATE	
24. FUNERAL DIRECTOR NAME <b>REDD FUNERAL HOME</b> ADDRESS <b>5209 YORK ROAD 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 09 1986</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

07/84  
25M

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DHMH - 17  
(VR A15 ME (5))

1912

1912-00-00

1912-00-00

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1912-00-00

00-02773

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10476  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOUR MIN.	
Augusta Bowen		4/5/86		1:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female	Caucasian	MONTH DAY YEAR 1/17/91		95 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
New York	U.S.A.			Baltimore City MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Sinai Hospital		Typist		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD		B. City	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1315 Appleby Ave. 21209
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST Adolph Kronmeyer			FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		062 05 3997		Herbert W. Bowen Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) right CVA → vegetative state					2 wks
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/20, 1986, to 4/5, 1986, that (I) (we) last saw the deceased alive on 4/5, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
Richmond P. Allan MD				4/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Richmond P. Allan				Sinai Hospital of Baltimore	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		04/08/86		Woodlawn Cemetery	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR			
Baltimore, Maryland		APR 07 1986			
24. FUNERAL DIRECTOR		25a. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS Burgee-Henss Funeral Home, Baltimore, Md.					

Green

April 27

Female

March 11/22

88

x

U.S. Nat.

U.S. Nat. Museum

NO. 1254

1215 Adams Ave.

Controlled Market

March 22 - Washington State

812

512

412

W. H. M.

W. H. M.

W. H. M.



Item #1 6/3/86 mtb F#616

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0477

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		DATE ESTI-MATED		MONTH		DAY		YEAR		2b. HOUR						
Joel		Jerome				Bowers		6/ 27/ 1986		4/ 27/ 1986								M						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR				
M		B		12 15 59		26 YRS.		MONTHS		DAYS		HOURS		MIN.		4/ 27/ 1986				1:25				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH												
N.J.				U.S.A.								Baltimore City, MD												
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY								
Baltimore				University Hospital								N/A												
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																								
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS								
MARYLAND								BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				1715 W.MOSER STREET								
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME														
FIRST										FIRST														
OTTO										VIOLA LEE														
MIDDLE										MIDDLE														
										DREHER														
LAST										LAST														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS				
NO										218807424					VIOLA BOWERS					1715 W.MOSHER				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> .	Multiple Gunshot Wounds DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION	19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
	21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:00 PM 4/ 27/1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot	
	21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1000 Blk. Vincet St., Balto. City, Md.	

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐.

\_\_\_\_\_  
ACTUAL SIGNATURE TITLE (SPECIFY)  
M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 4/27/86

EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL		5-2-86	MOUNT AUBURN	BALTIMORE		MARYLAND
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
WM.C.MARCH F/H INC. ADDRESS 1101 E.NORTH AVE.				MAY 1 1986	<i>[Signature]</i>	

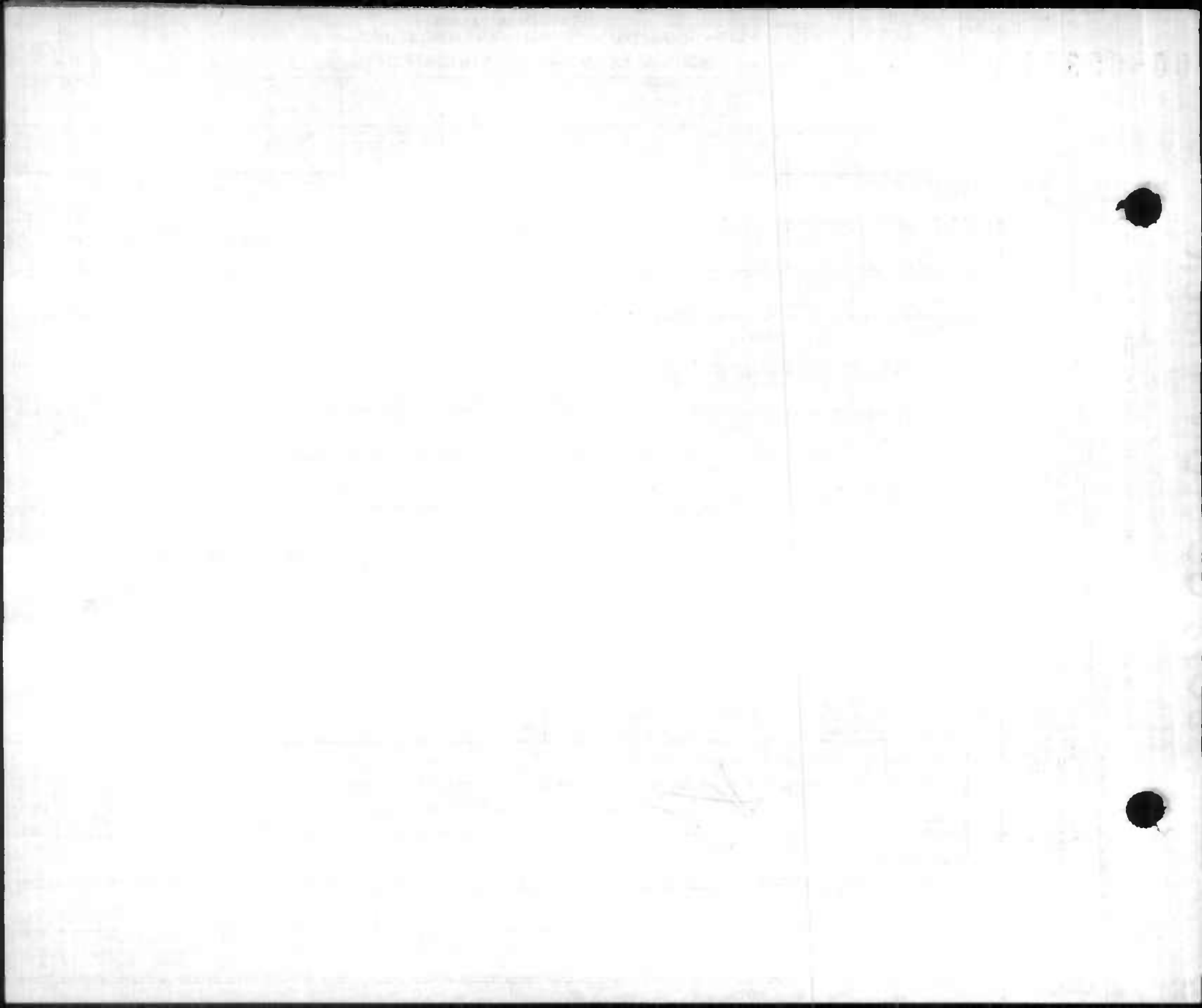
**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

DHMH - 17  
(VR A15 ME (5))



00-03913

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10478

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
CELESTE				BOYER	4-14-86					2:26 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	Black	MONTH 12 DAY 2 YEAR 1909			76 YRS.		MONTHS		DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.				Baltimore city MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore	Lutheran Hospital				Elevator Operator					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE						
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1100 Pennsylvania Ave. 21217						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
JESSIE		ELIZABETH			AUTHUR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NO		29-18-2715		Gregory Ratliffe 4547 Finney St. 21215						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Pulmonary embolus										
DUE TO, OR AS A CONSEQUENCE OF (b) Obstructive uropathy & Renal Failure										
DUE TO, OR AS A CONSEQUENCE OF (c) Squamous carcinoma of cervix & metastases										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)						
		HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 4/6, 1986, to 4/14, 1986, that (I) (we) lost										
saw the deceased alive on 4/14, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
BICH T DUONG		M.D.					4-14-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
BICH T DUONG		LUTHERAN HOSPITAL								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY STATE		
Burial		4-18-86		Eastview Cemetery		Baltimore		Maryland		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Bailey-Douglass Funeral Home 1348 N. Calhoun St.				APR 17 1986						

BP

00-03013

002-11 PMS

00-03966

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

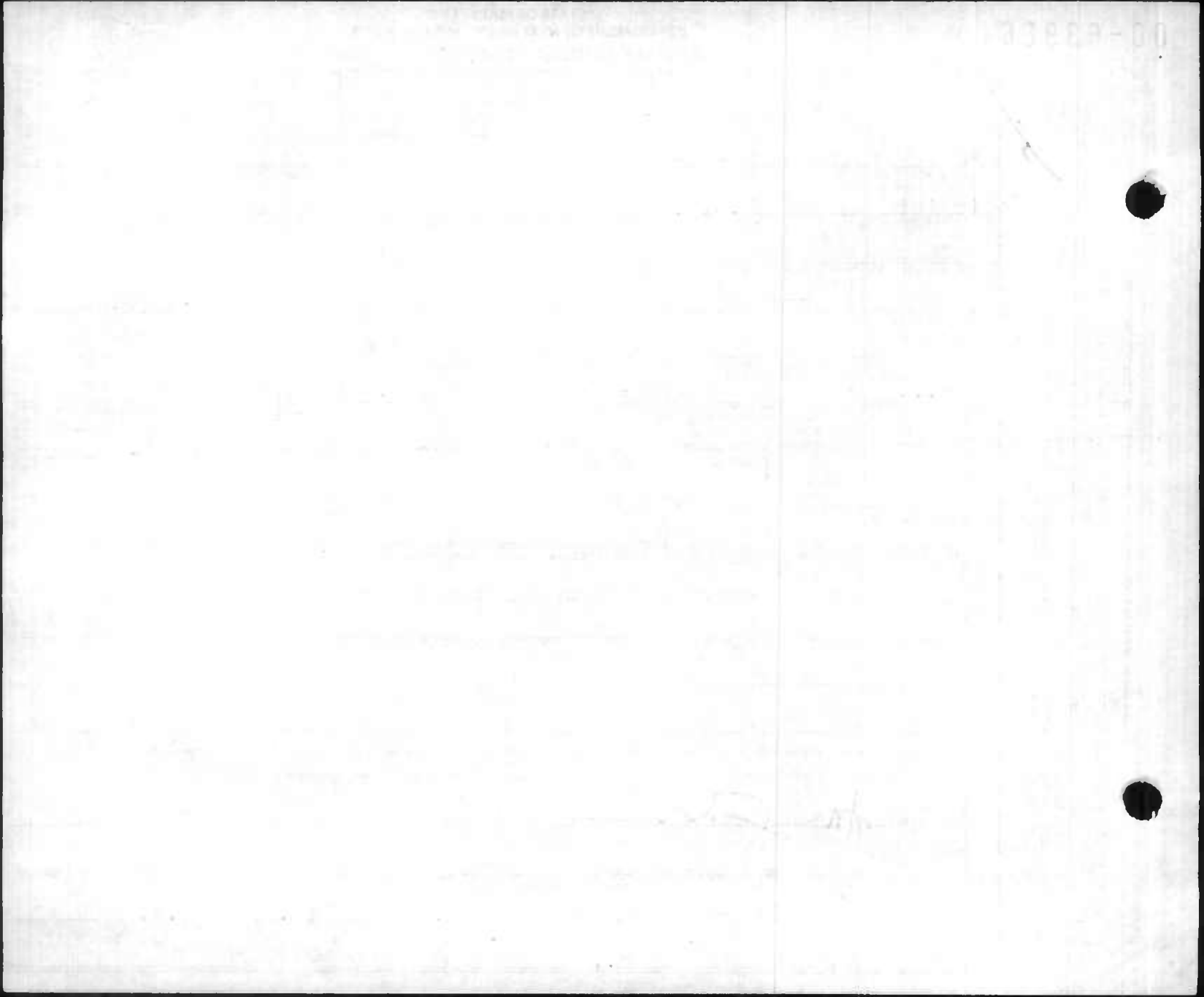
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0 0 4 7 9	
1. DECEASED NAME (TYPE OR PRINT) <u>ADERON</u> <u>VADERIAN X</u> <u>T.</u> <u>BRANHAM</u>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <u>4</u> DAY <u>13</u> YEAR <u>1986</u>	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>09</u> DAY <u>16</u> YEAR <u>40</u>		6. AGE (IN YEARS) (LAST BIRTHDAY) <u>45</u> YRS.		IF UNDER 1 YR. MONTHS <u>    </u> DAYS <u>    </u>		IF UNDER 24 HRS. HOURS <u>    </u> MIN. <u>    </u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>				7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>truck-3529 S. Hanover St.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <u>MD</u>		13b. COUNTY <u>---</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>3812 Tenth St. 21225</u>			
14. FATHER'S NAME FIRST <u>ADERON</u> MIDDLE <u>    </u> LAST <u>BRANHAM</u>						15. MOTHER'S MAIDEN NAME FIRST <u>GERTRUDE</u> MIDDLE <u>    </u> LAST <u>ROBINSON</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No...</u>				16b. SOCIAL SECURITY NO. <u>220-36-6337</u>		17. INFORMANT ADDRESS <u>Ernest L. Siddons Same as #13</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>888</u> IMMEDIATE CAUSE (a) <u>Acute epidural hematoma (left)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>    </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>    </u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Alcoholism</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>? P.M. 4-12- 1986</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) <u>Subject fell and struck head.</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>    </u>		21f. LOCATION STREET <u>    </u> CITY OR TOWN <u>Baltimore</u> COUNTY <u>    </u> STATE <u>MD</u>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Ann M. Dixon</u>				TITLE (SPECIFY) M.D. <u>Assistant</u> MEDICAL EXAMINER				DATE SIGNED <u>4-16-86</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>Ann M. Dixon, M.D.</u>				ADDRESS <u>111 Penn St., Balto., MD 21201</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>4-18-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>				23d. LOCATION CITY OR TOWN <u>Balto.</u> COUNTY <u>A.A.</u> STATE <u>MD</u>	
24. FUNERAL DIRECTOR NAME <u>McCully Funeral Home Balto., MD 21225</u>				25a. DATE REC'D. BY REGISTRAR <u>APR 18 1986</u>				25b. REGISTRAR'S SIGNATURE <u>John M. Dixon</u>			

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



00-05224

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with you 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>JOA L. BRAVE</b>					2a. DATE OF DEATH MONTH <b>04</b> DAY <b>26</b> YEAR <b>86</b>		2b. HOUR <b>8<sup>PM</sup></b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>06</b> DAY <b>25</b> YEAR <b>99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAE OF BALTIMORE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTIMORE</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7211 PARK HTS. AVE. 21208</b>		
14. FATHER'S NAME FIRST <b>ROBERT</b> MIDDLE <b>LIPNICK</b> LAST <b>LIPNICK</b>					15. MOTHER'S MAIDEN NAME FIRST <b>MIRIAM</b> MIDDLE <b>WOLF</b> LAST <b>WOLF</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-74-1313</b>		17. INFORMANT <b>MR. MARVIN BRAVE</b> <b>123 E. MONTGOMERY ST. #21230</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Massive CVA</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>HTN, ASD, Poor Suture S/P ME ECH</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>04/07</u> 19 <u>86</u> to <u>04/26</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>04/26</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Frederick J. Von Ben</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>4/26/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FREDERICK J. VON BEN</b>					22e. ADDRESS <b>SINAE OF BALTIMORE</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APR. 28, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH FILOH -</b>		23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>					25a. DATED BY REGISTRAR <b>APR 30 1986</b> 25b. REGISTRAR'S SIGNATURE				

BP

45870-00



0-03670

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 0 4 8 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Guy Ella Braxton			2a. DATE OF DEATH MONTH DAY YEAR 4 - 10 - 1986		2b. HOUR M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11-9- 1892		6. AGE (IN YEARS LAST BIRTHDAY) 93 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2315 Bryant Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Lester Brewster		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie F. Martin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 217-70-1195		
17. INFORMANT ADDRESS 2315 Bryant Avenue Baltimore, Md. 21217								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive cardiovascular disease</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>1978</u> to <u>4-8</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4-8-86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22a. SIGNATURE <u>Joseph R. Myerowitz</u>				22b. ADDRESS <u>6615 REISTERSTOWN RD. 21215</u>		22c. DATE SIGNED <u>4-14-86</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-15-1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary J Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ann Arundel Md.		
24. FUNERAL DIRECTOR Nutter & Sons Funeral Home, Inc. 2501 Gwynns Falls K Pkwy Baltimore, Md. 21216				25a. DATE REC'D BY REGISTRAR APR 15 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Baird-Randall</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



UNIVERSITY OF  
LIBRARY

0-03365

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					86 10482 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY E BREFFLE					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 4 7 86 1:25 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 1, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Essex					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 48 Orville Rd. 21221		
14. FATHER'S NAME FIRST MIDDLE LAST William Quillin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Phillips				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213 20 2009		17. INFORMANT Annette Bernard		2027 Middleborough Rd. Balto., Md. 21221			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) COPD, PNEUMONIA, MUSCULAR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DYSTROPHY DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (the hospital) attended the deceased from 2/24, 1986, to 4/7, 1986, that (b) (we) lost saw the deceased alive on 4/7, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (c) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Tullio Emanuele, MD					DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/7/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TULLIO EMANUELE					22e. ADDRESS 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239				
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 4/10/86		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR Muzdzinski					Funeral Home 1407 Old Eastern Ave		25a. DATE REC'D. BY REGISTRAR APR 11 1986		25b. REGISTRAR'S SIGNATURE James R. Riddell

0-03662

02 NOV 1960

GENERAL INVESTIGATIVE  
DIVISION, FBI

00-03071

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10483

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRY A. BREMER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-3-86</b>		2b. HOUR <b>2-00 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 25, 1925</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Roofer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Roofing</b>
13a. USUAL RESIDENCE (IF HAVING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>md</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>36 S. Ritters LA. 21117</b>		

14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry August Bremer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Naomi M. Ruark</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII 219-12-7973</b>	17. INFORMANT ADDRESS <b>PAUL L. Amick 36 S. Ritters LA. Owings Mills, Md 21117</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic oat cell carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF <b>lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**C-I Bleeding**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> a) WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/28/86</b> , 19 <b>86</b> , to <b>4/3/86</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/3/86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>R.M. Shah, M.D.</b>	DEGREE <b>M.D.</b>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.M. SHAH</b>	22e. ADDRESS <b>North Charles General Hospital, Baltimore MD</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>	23b. DATE <b>4/5/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>H.J. Eckhardt Owings Mills, Md</b>		25. DATE REC'D. BY REGISTRAR <b>APR 7 1986</b>	
		25b. REGISTRAR'S SIGNATURE <b>John S. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, or medical examination was performed, attach and forward page 4.

MEDICAL CERTIFICATION



00-05132

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED NON MED DR. D. SMYTH PER MR. FREEMAN

TO HOSPITAL OR ATTENDING PHYSICIAN. The low registered **DR. A. DIXON** be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 10484			
1- FOR STATE REGISTRAR					2a DATE OF DEATH MONTH DAY YEAR							2b HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CECIL L. BRINKLEY					APRIL 25, 1986					7:49A M			
3 SEX M		4 RACE B		5. DATE OF BIRTH MONTH DAY YEAR 2 11 15			6 AGE (IN YEARS LAST BIRTHDAY) YRS 71			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL					12a USUAL OCCUPATION (TYPE OR PRINT) STEEL WORKER		12b KIND OF BUSINESS OR INDUSTRY BETH-STEEL				
13a STATE MARYLAND					13b COUNTY		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 21213 2016 E. HOFFMAN ST.		
14 FATHER'S NAME FIRST MIDDLE LAST ANDREW BRINKLEY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA BROWN								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 213072291		17 INFORMANT ADDRESS BETTY LINTHICUM 2016 E. HOFFMAN ST.									
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupt. Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>history of seizures</u>													
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from <u>4/25/86</u> to <u>4/26/86</u> that (2) (we) last saw the deceased alive on <u>4/25/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Jonathan Israel</u> MD				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 4/26/86			
22d PHYSICIAN'S NAME (TYPE OR PRINT) JONATHAN ISRAEL				22e ADDRESS 600 W. Wolfe St Baltimore Md 21205									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE 4-30-86		23c NAME OF CEMETERY OR CREMATORY GARRISON FOREST			23d LOCATION CITY OR TOWN COUNTY STATE OWING MILLS MARYLAND				
24 FUNERAL DIRECTOR WM.C. MARCH F/H INC. 1101 E. NORTH AVE.						25a DATE REC'D. BY REGISTRAR APR 29 1986		25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Anderson</u>					

X





00-05877

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610483

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) LILLIAN LILLIAN BRISCOE BRISCOE			2a DATE OF DEATH MONTH DAY YEAR APRIL 29, 1986		2b HOUR 7:40 A.M.
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR Sept. 23- 07		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corporation		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY At Home
13a STATE Md.		13b COUNTY	13c CITY OR TOWN Balto.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William Johnson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgianna Robinson		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b SOCIAL SECURITY NO. 212-74-6358		17 INFORMANT ADDRESS Mrs. Dorothy Alford 1519 E. Chase St.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MULTIPLE DECUBITUS ULCERS AND GANGRENE LEFT FOOT</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>RECURRENT CEREBROVASCULAR ACCIDENT</u>			
19a DATE OF OPERATION APRIL 28, 1986	19b CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE LEFT FOOT	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that (I) (this hospital) attended the deceased from <u>APRIL 27</u> , 19 <u>86</u> , to <u>APRIL 29</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>APRIL 29</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <u>G. Guruswamy</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c DATE SIGNED 4/29/86
22d PHYSICIAN'S NAME (TYPE OR PRINT) GURUSWAMY GOPAL GURUSWAMY		22e ADDRESS CHURCH HOSPITAL CORPORATION M.D. 100 N. BROADWAY BALTO., MD. XXXXX	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 5-2-86	23c NAME OF CEMETERY OR CREMATORY Mt. Auburn Ctry.	23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24 FUNERAL DIRECTOR NAME Randolph J. Collick		25 DATE REC'D. BY REGISTRAR MAY 7 1986	
ADDRESS 24316 Oliver St.		REGISTRAR'S SIGNATURE Julia Davidson-Randall	



00-04329

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10486

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EUGENE G BRITTAIN SR			2a. DATE OF DEATH MONTH DAY YEAR 4 20 86		2b. HOUR 7 <sup>50</sup> P.M.	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 26 04		
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. CITY OR TOWN OF DEATH BALTIMORE		9. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSP.		10. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		
11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY Meat Packing		
13b. CITY OR TOWN PISDVENA		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15. STREET ADDRESS / ZIP CODE 1258 HILLSIDE RD. 21122		
16. FATHER'S NAME FIRST MIDDLE LAST ===== BRITTAIN		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY C=====		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
19. SOCIAL SECURITY NO. 413097923		20. INFORMANT Erika P. Brittain		21. ADDRESS Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Benign Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Systemic Candidiasis</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Acute Renal Failure</u>						
19a. DATE OF OPERATION 3/31/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca of head of pancreas</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> , 19 <u>86</u> , to <u>4/20</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>4/20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Rony Porodominsky</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/20/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rony Porodominsky		22e. ADDRESS 3001 S. HANOVER ST. BALTIMORE, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/23/86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md		24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonca 4001 Ritchie Hwy Balto Md				
25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>				

BP

33010-00

RECEIVED



RECEIVED

...once 40X ...

00-04652

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and place them in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10487  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William F. Brock</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4 13 86</b>		2b. HOUR <b>1145 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 28 76</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wyman Park Hospital System</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Merchant Marine</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Randalltown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Stewart Brock</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Violet Harris</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>COAST GUARD discharged 1942</b>		16b. SOCIAL SECURITY NO. <b>055-03-6420</b>		17. INFORMANT NAME ADDRESS <b>Stella Brock Same as deceased</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Immuno compromise</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cat cell Lung Cancer</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b> <b>10 days</b> <b>March 5, 1986</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>March 5, 1986</b> to <b>April 13, 1986</b> , that (I) (we) lost saw the deceased alive on <b>April 13, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Michael Miller MD</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael Miller MD</b>				22e. ADDRESS <b>Wyman Park Hospital Baltimore MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/16/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie Anne Arundel MD</b>		23e. DATE REC'D. BY REGISTRAR <b>APR 22 1986</b>			
24. FUNERAL DIRECTOR NAME <b>Barance FH. Severna Park MD</b>		25. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

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00-03969

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

10488

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>John Brogden</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4/11/1986</b>		2b. HOUR M <b></b>	
3. SEX <b>Male</b>	4 RACE <b>Black</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>3-19-1921</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>65</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, City</b> MD	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>711 Mc Cabe Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Steel Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>

13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>711 Mc Cabe Avenue 21212</b>
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14. FATHER'S NAME FIRST MIDDLE LAST <b>James Brogden</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Nooks</b>	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII 215-12-3016</b>	17 INFORMANT <b>Larry Brogden</b>	ADDRESS <b>7203 Wright Road Hanover, Maryland 21076</b>
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18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung ca</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Extensive Mediastinal</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Melanoma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **1-23-83** to **4-11-86**, that (I) (we) last saw the deceased alive on **4-2-86**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.

22b. SIGNATURE <b>[Signature]</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>4-15-86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4/17/1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Saint Rest Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Md.</b>
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24 FUNERAL DIRECTOR <b>Nutter &amp; Sons Funeral Home, Inc.</b> 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216	25a. DATE REC'D. BY REGISTRAR <b>APR 18 1986</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

00-09960



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

41

REPORT



00-05556

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be brought at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		86		10489		REG. NO.			
1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST Dora Brookman Beckman					2a. DATE OF DEATH MONTH DAY YEAR 4-28-86		2b. HOUR 5:00 A.M.		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3 11 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PRINCETON W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE MT. ZION NURSING HOME 21207	
14. FATHER'S NAME FIRST MIDDLE LAST C.A. CARTER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST S.A. CARTER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS LINDA DIXON 516 S. DUNCAN ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock - Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration pneumonia. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) S/P CPR. Pneumothorax @									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4-27 1986 to 4-28 1986, that (I) (we) last saw the deceased alive on 4-28 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B. L. THONG				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-28-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG				22e. ADDRESS LUTHERAN HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (Type or Print)		23b. DATE 4/30/86		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE A.A. COUNTY MD.		23e. DATE REC'D. BY REGISTRAR MAY 3 1986	
24. FUNERAL DIRECTOR NAME ADDRESS RAYMOND L. KACZOROWSKI 2525 FLEET ST.									

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1. The first part of the report  
 describes the general situation  
 of the project and the work  
 done during the last year.  
 2. The second part of the report  
 describes the results of the  
 work done during the last year.  
 3. The third part of the report  
 describes the results of the  
 work done during the last year.  
 4. The fourth part of the report  
 describes the results of the  
 work done during the last year.  
 5. The fifth part of the report  
 describes the results of the  
 work done during the last year.  
 6. The sixth part of the report  
 describes the results of the  
 work done during the last year.  
 7. The seventh part of the report  
 describes the results of the  
 work done during the last year.  
 8. The eighth part of the report  
 describes the results of the  
 work done during the last year.  
 9. The ninth part of the report  
 describes the results of the  
 work done during the last year.  
 10. The tenth part of the report  
 describes the results of the  
 work done during the last year.

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00-05256

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

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DHMH - 16 60M 7/B4  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 0 4 9 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY V BROOKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 28 86</b>		2b. HOUR <b>5:05 P.M.</b>
3 SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 25 1922</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3241 Phelps Lane 21229</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sidney Love</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marion Crenshaw</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-22-3921</b>		17. INFORMANT ADDRESS <b>Karen Brooks 3241 Phelps Lane 21229</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>TUBERCULOUS PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 HOURS</b> <b>MONTHS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>James E Taylor</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4/29/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES E. TAYLOR, M.D.</b>		22e. ADDRESS <b>ST AGNES HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>05-02-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Brown/Thompson F.H. 1913 W. Baltimore Street</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 30 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **10491**

**1- FOR  
STATE  
REGISTRAR**

1 DECEASED NAME (TYPE OR PRINT)			2a DATE KNOWN OF DEATH			2b HOUR		
FIRST MIDDLE LAST <b>Albert Brown</b>			MONTH DAY YEAR <b>4 20 19 86</b>			M <b>12:23 P.M.</b>		
3 SEX <b>Male</b>	4 RACE <b>Black</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>12 11 1909</b>	6 AGE (IN YEARS) LAST BIRTHDAY <b>76</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4 20 19 86</b>		2d HOUR <b>12:23 P.M.</b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1644 N. Monroe St.</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Maryland</b>			13b COUNTY		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John (Brown) Brown</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Mathews</b>			13e STREET ADDRESS <b>1644 N. Monroe St., 21217</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO. <b>216-05-2939</b>		17 INFORMANT ADDRESS <b>Barbara Brown 1644 N. Monroe St., 21217</b>			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I :

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f LOCATION CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held an autopsy ☐ inspection ☐ inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE *Dennis F. Smyth* TITLE (SPECIFY) **Assistant** MEDICAL EXAMINER DATE SIGNED **4-21-86**

EXAMINER'S NAME (TYPE OR PRINT) **Dennis F. Smyth, M.D.** ADDRESS **111 Penn St., Balto., MD 21201**

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>4-24-86</b>	23c NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Cemetery Owings Mills</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Maryland</b>
24 FUNERAL DIRECTOR NAME ADDRESS <b>Bailey-Douglass Funeral Home 1348 N. Calhoun St.</b>		25a DATE REC'D. BY REGISTRAR <b>APR 29 1986</b> 25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1 2020-5

00-04415

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

36 REG. NO. 10492

1 DECEASED NAME (TYPE OR PRINT) Barron Alexander Brown			2a DATE OF DEATH MONTH DAY YEAR 11/19/86		2b HOUR 9:15 AM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 02 06 22		6 AGE (IN YEARS (LAST BIRTHDAY)) 64 YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH City MD.		
10 CITY OR TOWN OF DEATH Baltimore	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lock Raven Veterans Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland	13b COUNTY Balto.	13c CITY OR TOWN Essex	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Marvin Brown		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Duncan				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO. WW 11 246-03-5200		17 INFORMANT Thelma Brown 413 Wolf Street 21221		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inferior Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 4/19, 1986, to 4/19, 1986, that (I) (we) last saw the deceased alive on 4/19/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.						
22b SIGNATURE G. Fromell		DEGREE		22c DATE SIGNED 4/19/86		
22d PHYSICIAN'S NAME (TYPE OR PRINT) G. Fromell		22e ADDRESS Lock Raven Veterans Hospital				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4/23/86		23c NAME OF CEMETERY OR CREMATORY Gardens of Faith		
23d LOCATION Rossville Baltimore Maryland		24 FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221				
25a REG. BY REGISTRAR APR 23 1986		25b REGISTRAR'S SIGNATURE G. Fromell				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-10-10

General Affairs - General

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00-04507

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10493

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		4-22-86		4:15 PM	
3 SEX M		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
B		3 24 09		77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Balto.		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Balto.		Lutheran Hosp.		MD. 12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
md.				Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
unk.		unk.		13e. STREET ADDRESS / ZIP CODE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes		43-46 220185780		Geraldine Brown 3106 Windsor Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>decubitus ulcers</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>osteomyelitis</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/21/86 11/39/86 1986, to 4/22/86 1986, that (I) (we) last saw the deceased alive on 4/21/86 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
Moges Gebremariam				4-22-86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		4-24-86		Westview Cem. Catonsville Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Margaretta Brown-Jones		3106 Walbrook Ave		APR 24 1986 Julia Davidson-Randall	

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00-05414

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 10494

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bertha Brown			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4/27 1986			2b. HOUR M 3:47		
3. SEX Fe	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 10 1 20	6. AGE (IN YEARS) (LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4/27 1986		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AM Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Luthern Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. STREET ADDRESS 1031 N. Mount St. 21217		
14. FATHER'S NAME FIRST MIDDLE LAST Hezekiah Braxton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Shristian				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 21628 1393		17. INFORMANT ADDRESS Mildred Brown 1031 N. Mount St.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Diabetes Mellitus and Obesity

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

REISSUED: 5/1/86

ACTUAL  
SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE  
SIGNED 4/27/86EXAMINER'S NAME  
(TYPE OR PRINT)

Gregory R. Kauffman, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/2/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Jas. A. Morton & Sons 1701 Laurens St.				25a. DATE REC'D. BY REGISTRAR MAY 2 1986		25b. REGISTRAR'S SIGNATURE	

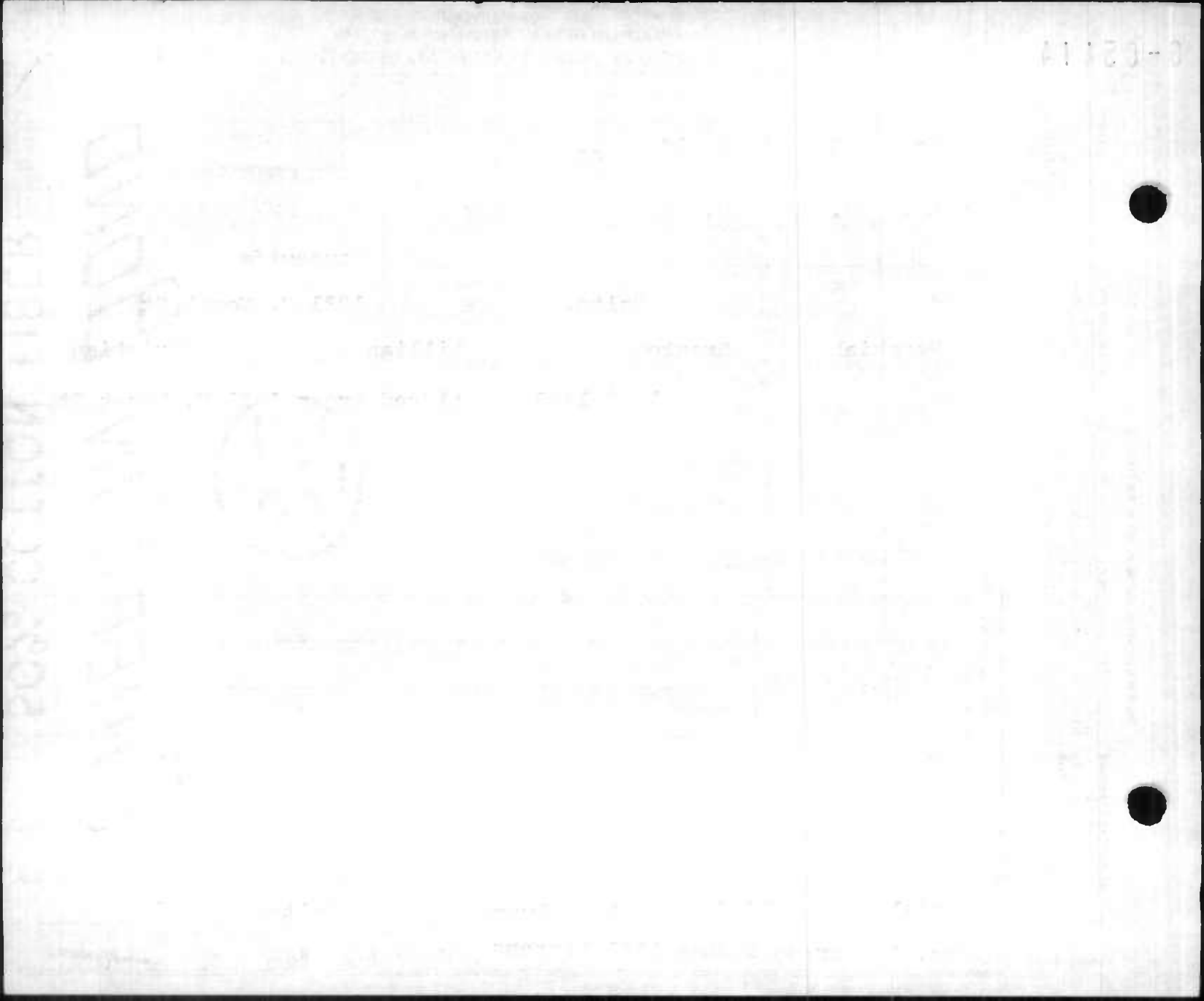
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10A.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
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00-02437

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10495  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Carrie B. Brown			2a. DATE OF DEATH MONTH DAY YEAR March 30, 1986		2b. HOUR M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11 6 19		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2210 Aiken Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1102 Druid Hill Ave. Apt. 407 21201	
14. FATHER'S NAME FIRST MIDDLE LAST Columbus Walter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Richardson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown		16b. SOCIAL SECURITY NO. 215-24-3260		17. INFORMANT ADDRESS Freddie Wright 4901 York Road Apt. A4	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arterial Sclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-6-86</u> 19 <u>86</u> , to <u>3-30-86</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3-30-86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4-1-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/3/86	23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME MARCH FUNERAL HOMES 1101 E North Avenue			25a. DATE REC'D. BY REGISTRAR APR 3 1986		
			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

86 10495

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elsie M. Brown</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>04 09 86</b>		2b. HOUR <b>5:55pm</b>	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 06 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wyman Park</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		13a. STATE <b>MD</b>	
13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Horace Stiffler</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>not known</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	
16b. SOCIAL SECURITY NO. <b>216 804748</b>		17. INFORMANT <b>Ruth Leight; same as patient</b>		ADDRESS <b>3608 Keswick Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blastic Crisis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Myelocytic leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>?</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 (16mo.)</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/9/86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>4/9/86</b>			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4/9/86</b>		22a. I certify that (I) (this hospital) attended the deceased from <b>4/9/86</b> 19____, to <b>4/9/86</b> 19____, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>D. Holcombe</b>		DEGREE		22c. DATE SIGNED <b>4/9/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David J. Holcombe</b>		22e. ADDRESS <b>3100 Wyman Park Drive Baltimore MD 21211</b>		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/12/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn Gardens</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>A. Alan Seitz, Jr. 3615-19 Chestnut Ave. 21211</b>			
25a. DATE REC'D. BY REGISTRAR <b>APR 11 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10491  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) VS. ELLWOOD ELWOOD BROWN.		2a DATE OF DEATH MONTH DAY YEAR 04/24/1986		2b HOUR 11:30 AM
1 SEX M	4 RACE B	5 DATE OF BIRTH MONTH DAY YEAR 12 23 99		6 AGE (IN YEARS LAST BIRTHDAY) 86
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD
10 CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NIA	12b KIND OF BUSINESS OR INDUSTRY
13a STATE MARYLAND		13b COUNTY	13c CITY OR TOWN BALTIMORE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST FRANK BROWN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE VICTOR		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-6148	17 INFORMANT ADDRESS MARY E. PAYNE 2613 N.33rd. PHILA. PA. 19132		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOVASCULAR - SEVERE CARDIOPATHOSIS DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ATHEROSCLEROSIS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a SEPTICEMIA - PULMONARY ATLECTASIS				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1, OR PART 2)		
21d INJURY OCCURRED DURING <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 04/07/1986 to 04/24/1986, that (I) (we) last saw the deceased alive on 04/24/1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE [Signature]	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 4/24/86
22d PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY M.D.		22e ADDRESS NORTH CHARLES HOSPITAL BALTIMORE, MD 21218		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 4-29-86	23c NAME OF CEMETERY OR CREMATORY MOUNT ZION	23d LOCATION CITY OR TOWN COUNTY STATE LANSDOWNE MARYLAND	
24 FUNERAL DIRECTOR NAME WM.C.MARCH F/H INC. 1101 E. NORTH AVE.		25a DATE REC'D. BY REGISTRAR APR 29 1986		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10498  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Emma Brown</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>April 27, 1986</b>		2b. HOUR <b>3:20A</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 15 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>	13b. COUNTY	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2312 Callow Ave. 21217</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dave Fisher</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Cokely</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-12-0503</b>	17. INFORMANT ADDRESS <b>Ollie Sumpter 2312 Callow Ave.</b>		

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio/Respiratory Arrest</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b>				
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Disease</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OR CONDITION GIVEN IN PART 1: <b>Prior, Left Cerebrovascular Accident, Sepsis, Chronic Renal Failure, Decubiti, Urinary Tract Disease, Advanced Age</b>				
19a. DATE OF OPERATION <b>April 26, 1986</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Emergency Debridement of Decubiti</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <b>April 22</b> , 19 <b>86</b> , to <b>April 27</b> , 19 <b>86</b> , that (1) we lost saw the deceased alive on <b>April 27</b> , 19 <b>86</b> , and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above, (2) we (did) (did not) view the body after death.				
22b. SIGNATURE <b>(Zickler)</b>	DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4/27/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Roderick Zickler, M.D.</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5-1-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>Bailey-Douglass 1348 N. Calhoun St.</b>		25a. DATE REC'D BY REGISTRAR <b>MAY 1 1986</b>		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8610499

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Hettie Brown</b>			2a DATE OF DEATH MONTH DAY YEAR <b>April 15, 1986</b>		2b HOUR M <b></b>	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>1 27 04</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. <b>82</b>		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>824 Bradhurst Road</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD</b>		
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Leafus Salvatore</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gillis Green</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>212-12-6159</b>		17 INFORMANT ADDRESS <b>Hoarsell Colbert 824 Bradhurst Rd.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure and Cardiac Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerotic and Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Severe Bacterial Arthritis, Anemia</b>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <b>4/13/86</b> to <b>4/15/86</b> , that (I) (we) last saw the deceased alive on <b>4/13/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
23a SIGNATURE <b>Marquet A. Fountain, MD</b>		DEGREE <b>MD</b>		22c DATE SIGNED <b>4/15/86</b>		
23b PHYSICIAN NAME (TYPE OR PRINT) <b>M.A. Fountain</b>		23c ADDRESS <b>2145 S. Quadrangle, Baltimore, Md.</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>4/19/86</b>		23c NAME OF CEMETERY OR CREMATORY <b>Druidridge Cem</b>		
23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>		24 FUNERAL DIRECTOR NAME ADDRESS <b>March Funeral Home West 4300 Wabash Avenue</b>				
25a DATE REC'D. BY REGISTRAR <b>APR 18 1986</b>		25b REGISTRAR'S SIGNATURE <b>John Anderson</b>				

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10500  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Iretha LUNA brown.			2a. DATE OF DEATH MONTH DAY YEAR 04 15 86			2b. HOUR 10 <sup>08</sup> A.M.	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 09 02 13		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	

10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF MARYLAND		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY	
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USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4631 REISTERSTOWN RD.		
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.				

14. FATHER'S NAME FIRST MIDDLE LAST JOHN THOMPSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE BROWN		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 228-03-7230		17. INFORMANT ALEXSE BROWN		ADDRESS 4631 REISTERSTOWN RD.	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute coronary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>multiple myeloma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHF</u>			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 7)			
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21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
-----------------------------------------------------------------------------------------------------------	--	------------------------------------------------------------------------	--	---------------------------------------------------	--	--	--

22a. I certify that (I) (this hospital) attended the deceased from <u>4/19</u> , 19 <u>86</u> , to <u>4/19</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/19</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	--	--	--	--	--

22b. SIGNATURE <u>Friedrich J. von B...</u>			DEGREE M.D.			22c. DATE SIGNED		
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRIEDRICH J. VON B...			22e. ADDRESS SINAI HOSP. OF BALTIMORE				
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-19-86		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM.		23d. LOCATION BALTIMORE, MARYLAND	
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24. FUNERAL DIRECTOR NAME ADDRESS BROWN THOMPSON F. H. 1913 W. BALTO. ST.			25a. DATE REC'D. BY REGISTRAR APR 18 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson		
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

MEDICAL CERTIFICATION





0-04946

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10501

REG. NO.

FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>(James) Jimmie</b> <b>Brown, Sr</b>			2a DATE OF DEATH MONTH DAY YEAR <b>4 22 86</b>		2b HOUR <b>2:35 A.M.</b>
3 SEX <b>m</b>	4 RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 17 17</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN) <b>South Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secure Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
13a STATE <b>M.D.</b>		13b COUNTY <b>Baltimore</b>		13c STREET ADDRESS / ZIP CODE <b>1135 N. Stricker St. Balto</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Lee Brown</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leola wines</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Steel Bethlehem</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. <b>250-07-2630</b>		17 INFORMANT <b>Ms Louise Frost</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>912</b> IMMEDIATE CAUSE (a) <b>Cardiovascular arrest</b> DUE TO, OR AS A CONSEQUENCE OF <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Aspirations</b> DUE TO, OR AS A CONSEQUENCE OF <b>Aspirations</b> (c) <b>Aspirations</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>C.H.F., C.R.F., Hypertension</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (this hospital) attended the deceased from <b>4-3-86</b> to <b>4-22-86</b> that (two) last saw the deceased alive on <b>4-21-86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (or was) (and did not) view the body after death.					
22b SIGNATURE <b>A. Miranda</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>4.22.86</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. MIRANDA</b>		22e ADDRESS <b>1810 St. Paul St - 21202</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>4-28-86</b>		23c NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Veteran</b>	
23d LOCATION CITY OR TOWN <b>Owings Mills</b>		COUNTY <b>MD</b>		STATE	
24 FUNERAL DIRECTOR NAME <b>Joe C March</b>		ADDRESS <b>4300 Wabash Ave.</b>		25a DATE REC'D. BY REGISTRAR <b>APR 28 1986</b>	
25b REGISTRAR'S SIGNATURE <b>W.R.O.</b>		25c REGISTRAR'S SIGNATURE <b>W.R.O.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

04910-0

20% COTTON FIBER



00-03201

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH P.C.M. PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10502

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) THOMAS		DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 4 4 1986		HOUR 11:30 AM	
3 SEX Male	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 19 55	6. AGE (IN YEARS) (LAST BIRTHDAY) 36 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Showell Pol. Labor		12b. KIND OF BUSINESS OR INDUSTRY Labor	
13a. STATE Maryland		13b. CITY OR TOWN Salisbary	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS Rt #2 Box 192 West Road	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas H Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Everrett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Marine Corp.		16b. SOCIAL SECURITY NO. 219-60-0216		17. INFORMANT ADDRESS Doris Jones Rt #2 Box 192 West Road	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt trauma of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 7:40 P.M. 3 28 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject struck head during altercation	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bar		21f. LOCATION STREET CITY OR TOWN COUNTY STATE W. Main and Lake Sts. Salisbury Wicomico MD	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion					
ACTUAL SIGNATURE John E. Smialek, M.D.		TITLE (SPECIFY) Chief		DATE SIGNED 4-5-86	
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D.		ADDRESS 111 Penn St., Balt., MD.		20201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/9/86		23c. NAME OF CEMETERY OR CREMATORY Harlock VA	
24. FUNERAL DIRECTOR NAME Fork		ADDRESS 714 Salis		23d. LOCATION CITY OR TOWN COUNTY STATE Harlock DC MD	
25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson			

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



00-02872

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 10503

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HERBERT M. BRUNE, JR.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 5 86</b>		2b. HOUR <b>8:15P</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 8, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. <b>84</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Attorney</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>		13a. STATE <b>MD</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3915 Beech Ave., 21211</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Herbert M. Brune, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy F. Fisher</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218 18 1382</b>		17. INFORMANT ADDRESS <b>Robert C. Prem, Balto., MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>septic shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>bowel obstruction</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>4/5</u> 19 <u>86</u> to <u>4/5</u> 19 <u>86</u> , that (I) <u>we</u> last saw the deceased alive on <u>4/5</u> 19 <u>86</u> , and that (I) <u>we</u> <u>did not</u> view the body after death.							
22b. SIGNATURE <b>Jeffrey A. Cool</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/5/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeffrey A. Cool MD</b>		22e. ADDRESS <b>Union Memorial Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/9/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville, MD</b>	
24. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co.</b> NAME ADDRESS <b>4905 York Road Balto., MD 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 08 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Richard R. [Signature]</b>	



00-04216

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				86 NO. 10504			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY LOUISE BUCHANAN				2a. DATE OF DEATH MONTH DAY YEAR 4/15/86				2b. HOUR 6:45 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 31 09		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 2 YRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MASON T. LORD Mason T. Lord Building BLDG.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY BALTO. 13c. CITY OR TOWN BALTIMORE				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE APT. 217 2000 O'DELL AVE. 21237					
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL BURNS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALTHENA UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 294-05-0414		17. INFORMANT ADDRESS JOHN BUCHANAN (HUSBAND) APT. 8E 4320 CLAREWAY							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Interstitial Pulmonary Fibrosis</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/15/86 to 4/15/86, that (I) (we) last saw the deceased alive on 4/15/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Joseph A. Carrese				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Carrese				22e. ADDRESS 4940 Eastern Ave Balt MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 4/18/86		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.		
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE			





00-02489

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

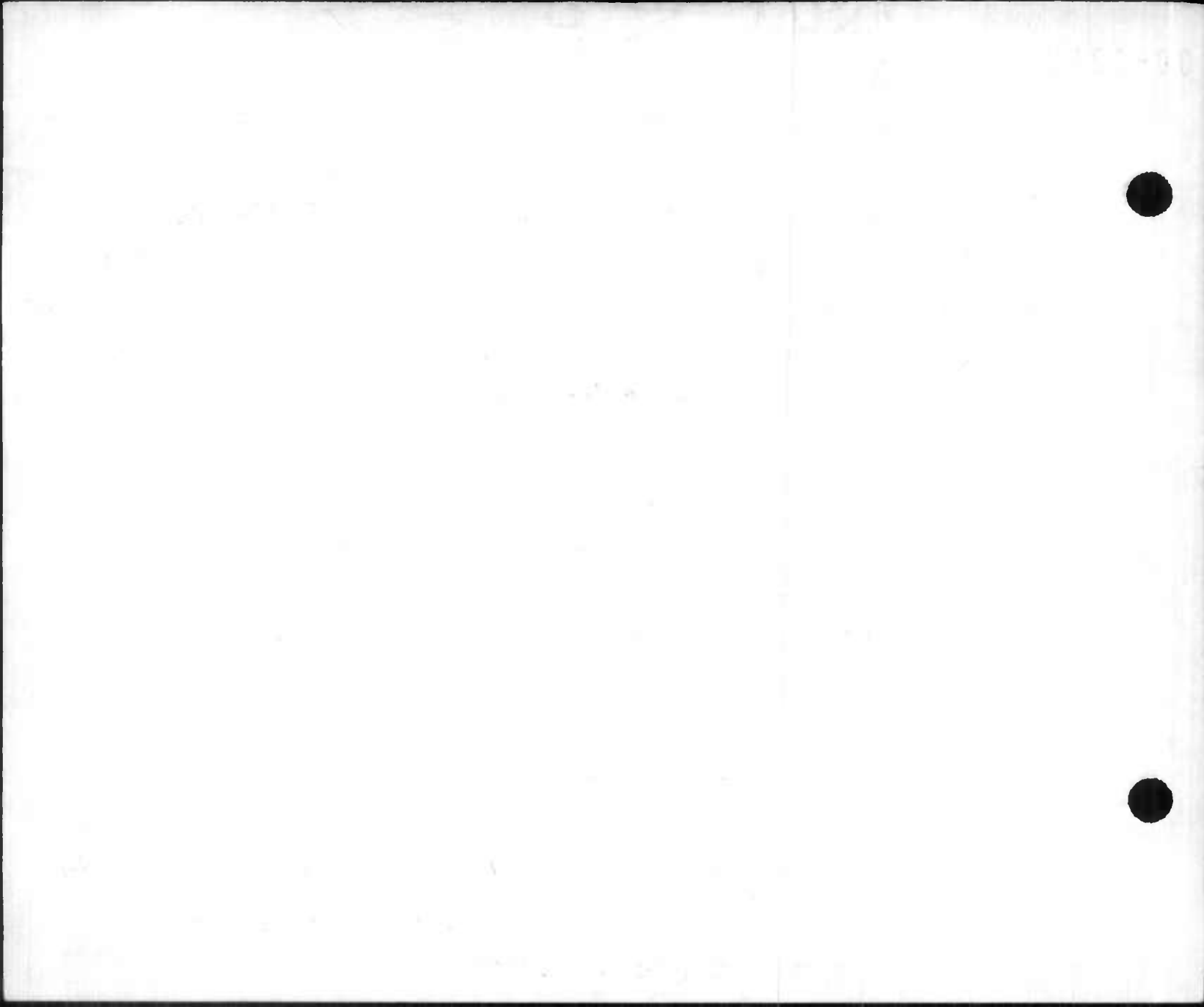
DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610505

REG. NO.

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>HELEN</b> <b>Rutherford</b> <b>BUCKLER</b>		2a. DATE OF DEATH MONTH <b>4</b> DAY <b>1</b> YEAR <b>'86</b>		2b. HOUR <b>3:48</b> PM	
3. SEX <b>F</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>31</b> YEAR <b>'13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILL</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Balto</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6303 Pinehurst Rd</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>6303 Pinehurst Rd 21212</b>	
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>Hall</b> LAST <b>McCormick</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Eleanor</b> MIDDLE <b>Morris</b> LAST <b>Morris</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-46-0116</b>	
17. INFORMANT <b>Daughter</b>		17a. ADDRESS <b>Joan Claybrook</b> <b>2034 37th St. NW</b>		17b. CITY OR TOWN <b>Wash. D.C.</b>		17c. STATE <b>20007</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>left Hemiplegic Stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Carcinoma of Breast with Metastasis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>2 days</b> <b>unknown</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Cachexia</b>							
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/22</b> 19 <b>84</b> to <b>4/1</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>3/31</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>P. Hinderberger</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/1/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Peter Hinderberger</b>		22e. ADDRESS <b>4801 Yellowwood Ave, Balto MD 21209</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>4/3/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley Inc. Balto., Md. 21222</b>				25a. DATE REC'D BY REGISTRAR <b>APR 03 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



00-04393



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 10506

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ERNEST B. BUEDING</b>			2a DATE OF DEATH MONTH DAY YEAR <b>4/18/86</b>		2b HOUR <b>3:05 PM</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 19, 1910</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4001 Roundtop Road</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Medical Doctor</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a STATE <b>Maryland</b>		13b COUNTY		13c CITY OR TOWN <b>Baltimore</b>		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>4001 Roundtop Rd. 21218</b>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>Frederick Bueding</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Margulief</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>275-30-1838</b>		17 INFORMANT ADDRESS <b>Raya P. Bueding 4001 Roundtop Rd. 21218</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cervical carcinoma, unknown primary</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 mo</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) <del>this hospital</del> attended the deceased from <b>2/3</b> 19 <b>75</b> , to <b>4/18</b> 19 <b>86</b> , that (1) <del>we</del> lost <del>the deceased alive on</del> <b>4/17</b> 19 <b>86</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (1) <del>we</del> did <del>not</del> view the body after death.						
22b. SIGNATURE 		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4/18/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Andrew P. Weintraub M.D.</b>		22e. ADDRESS <b>222 W. Calverly Lane Baltimore, Md 21210</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Apr 21 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>APR 22 1986</b>				
24 FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 22 1986</b>		
25b. REGISTRAR'S SIGNATURE 						

BP

WUDDY V

RENT

Aug. 19, 1910

Wife

John

at home of J. J.

U.S.A.

John

Medical Officer

NOT known to me.

John

at home of J. J.

John

John

at home of J. J.

John

John

at home of J. J. at home of J. J.

John



00-04146

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 10501	
1- FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST Averi Logan Bullen					4 16 86					9:55 M	
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
FEMALE		WHITE		4 21 99			86 YRS			MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.						City Baltimore City MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK, OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Mason F. Lord			Retired			W.R. Grace Co.			
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland							Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST Clarence D. Altvater					FIRST MIDDLE LAST Bertie Lee Mc Neal						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					215-07-7698		Philip A. Logan 629 S. Grundy St. 21224				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA										hours.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) CVA.	
DUE TO, OR AS A CONSEQUENCE OF										(c) years.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from 3/5/85, 19 to 4/16 19 86 that (b) (we) last saw the deceased alive on 4/16 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
E. Rogers, M.D.										April 17, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS			
E. Rogers, M.D.								Mason F. Lord Nursing Home			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial				4-21-86		Oak Lawn Cemetery			Eastwood, Balto Co. Md		
24 FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR			
Charles S. Zeiler & Son Inc. 6224 Eastern Ave.								APR 21 1986			

MEDICAL CERTIFICATION

BP

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905-77-712

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77-102

00-02697

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10508  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS B. BURCH			2a. DATE OF DEATH MONTH DAY YEAR 04/04/86		2b. HOUR 3:30 am
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 12 93		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Upholsterer		12b. KIND OF BUSINESS OR INDUSTRY Upholstery Co.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Burch			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara A. Unavailable		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWI 216 01 6625		17. INFORMANT ADDRESS William J. Burch 1719 Selma Ave. 21227	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest (Arythmia)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: } (b) <u>Hypoxemia/pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic heart disease</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 29</u> 19 <u>86</u> to <u>April 4</u> 19 <u>86</u> , that (I) (we) lost <u>April 4</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <u>David A. Jung MD</u>		DEGREE MD		22c. DATE SIGNED 4/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David A. Jung, MD.		22e. ADDRESS St. Agnes Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/7/86	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN Baltimore	COUNTY STATE Maryland
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REG'D BY REGISTRAR APR 07 1986	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

COLLIER HUGHES

2200

2100



2100



100-05661

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10509

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JACOB BURGAN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4. 29 86</b>		2b. HOUR <b>3 A M</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 2 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. (BALTIMORE CITY) OR COUNTY OF DEATH <b>BALTIMORE CITY MD</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINDALE</b>		12a. REPAIRMAN (WATCH) <b>JEWELRY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>JEWELRY</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>524 N. CHARLES ST., APT. 1613 #21201</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>BENJAMIN BURGAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GERTRUDE LAUTERBACH</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-01-3312</b>		17. INFORMANT <b>ISAAC HECHT</b> ADDRESS <b>1111 FIDELITY BLDG. BALTO., MD 21201</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCUD + SENILE DEMENTIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8-29-86</b> to <b>4-29-86</b> that (I) (we) last saw the deceased alive on <b>4-28-86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <b>Levinson</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>4:29:86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SET HTWAR</b>		22e. ADDRESS <b>LEVINDALE 2484 BELVERDERE AVE BALTIMORE, MD 21215</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>	23b. DATE <b>5/2/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW MEM. PARK</b>		23d. LOCATION <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS. INC.</b>		ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25a. DATE RECEIVED BY REGISTRAR <b>MAY 6 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

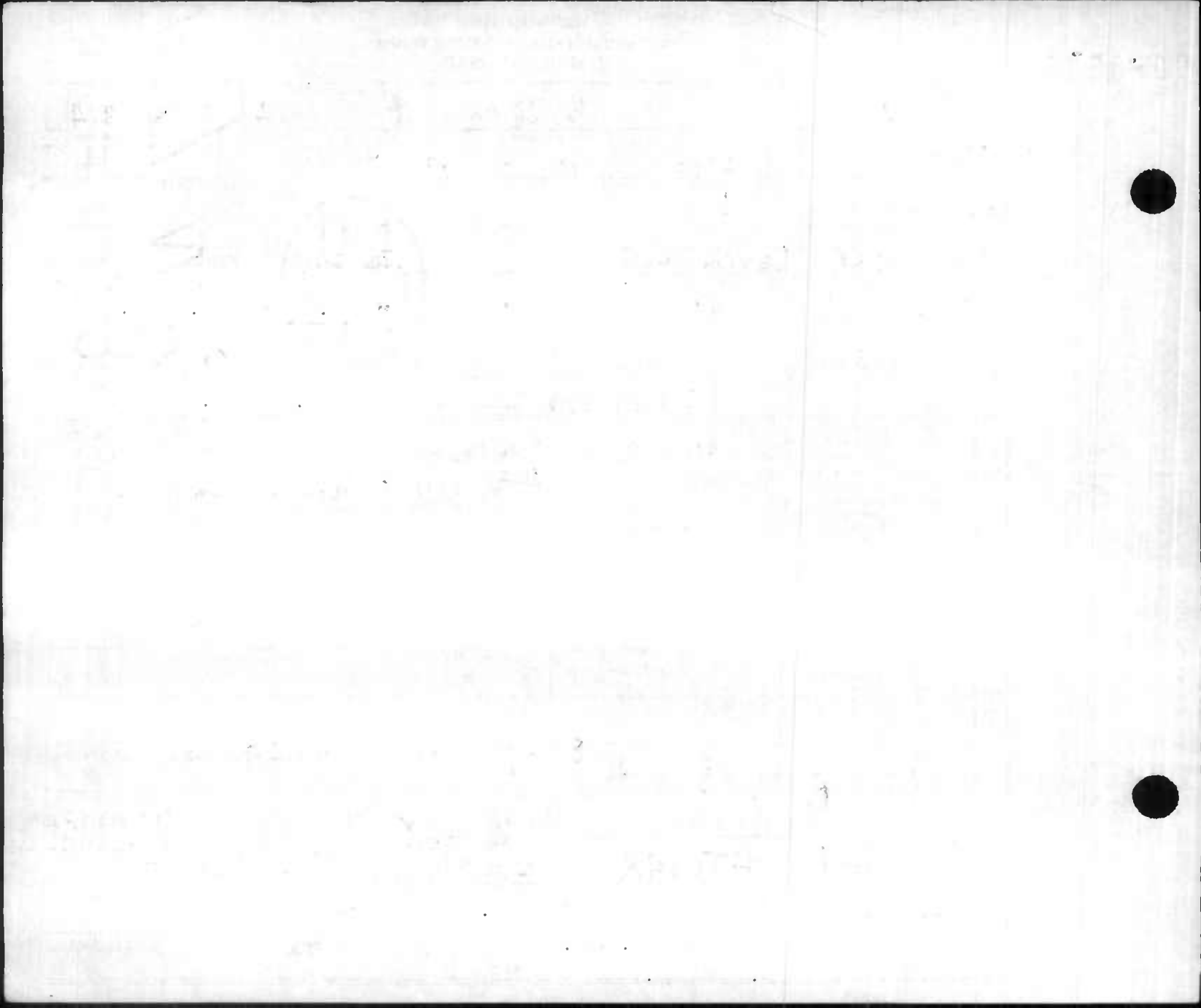
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



00-02591

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

10510

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Isabella Burke			2a DATE OF DEATH MONTH DAY YEAR April 1, 1986		2b HOUR M
3 SEX Female	4 RACE B	5 DATE OF BIRTH MONTH DAY YEAR 1 10 16		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10 CITY OR TOWN OF DEATH BALTIMORE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 WEST 20th STREET APT. 6R		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST DANIEL AQUILLA		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE LEWIS		13e STREET ADDRESS / ZIP CODE 11W. 20th ST. APT. 6R 21218	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 212-16-2132		17 INFORMANT ADDRESS THOMAS BURKE 11W. 20th ST. APT. 6R	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Re Colon</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Hours</u> <u>Months</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>Nov 88</u> to <u>4/1</u> 19 <u>86</u> , that (I) (we) last saw (he) (she) (it) (him) (her) (them) on <u>3/12/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b SIGNATURE <u>Donald M. Pacheco</u>		DEGREE		22c DATE SIGNED <u>4/2/86</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Donald M. Pacheco</u>		22e ADDRESS <u>2903 N Charles St</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 4-5-86	23c NAME OF CEMETERY OR CREMATORY MOUNT AUBURN		23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24 FUNERAL DIRECTOR NAME ADDRESS March Funeral Homes 1101 East North Avenue		25a DATE REC'D. BY REGISTRAR APR 04 1986		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The following requirements for the death certificate must be completed and returned by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

RELEASED NON-MED / DR. ANNE DIXON PER MR. PURVIS

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		86		10511		REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DANIEL LEWIS BURKETT					2a. DATE OF DEATH MONTH DAY YEAR APRIL 23, 1986			2b. HOUR 3:08 <sup>P</sup> M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 18 1986		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 6		7. UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ----		12b. KIND OF BUSINESS OR INDUSTRY -----		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Marion Todd Burkett					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Tracy Campbell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) --		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) --		17. INFORMANT M. Todd Burkett		136 Willow Dale Drive Frederick, MD 21701				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR UNRESPONSIVENESS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 min		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METABOLIC ACIDOSIS</u>								3 HRS		
(c) <u>TRICUSPID ATRESIA</u>								4 DAYS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>										
19a. DATE OF OPERATION 4-23-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TRICUSPID ATRESIA			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (the hospital) attended the deceased from <u>4-18</u> , 19 <u>86</u> , to <u>4-23</u> , 19 <u>86</u> , that (the doctor) saw the deceased alive on <u>4-23</u> , 19 <u>86</u> , and that in my opinion death occurred on the date and hour and from the causes stated above (I have) and did not view the body after death.										
22b. SIGNATURE <i>Dr. Casale</i>				DEGREE			22c. DATE SIGNED 4-23-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CASALE				22e. ADDRESS J H H						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-26-86		23c. NAME OF CEMETERY OR CREMATORY Grossnickle Brethren		23d. LOCATION CITY OR TOWN COUNTY STATE Myersville Frederick Maryland				
24. FUNERAL DIRECTOR <i>Walter L. Ricketts</i>				ADDRESS Ricketts Funeral Home Myersville, MD 21773		25a. DATE RECD. BY REG. BUREAU MAY 01 1986				

BP

MAJOR J. H. HARRIS

00-03279

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10512  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary M. Burnett</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4/7/86</i>			2b. HOUR <i>155 A.M.</i>	
3. SEX <i>F</i>		4. RACE <i>B</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 22 1897</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>88</i>	
7a. BIRTHPLACE (STATE OR FOREIGN) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>PROVIDENCE HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>DOMESTIC</i>	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>UNKNOWN</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i>		16. STREET ADDRESS / ZIP CODE <i>501 DOLPHIN STREET APT. 1112</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>214-26-6756</i>		17. INFORMANT ADDRESS <i>1112 MILDRED TAZEWEEL 501 DOLPHIN ST. APT.</i>			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Decubitus Ulcers</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>Diabetes Mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/7</i> , 19 <i>86</i> , to <i>4/7</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>4/7</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Eleanor Y. Hixon</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>4/7/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Eleanor Y. Hixon, MD</i>		22e. ADDRESS <i>3100 Towanda Ave.</i>					
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>		23b. DATE <i>4-11-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MOUNT ZION</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>LANDOWN MARYLAND</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>WM.C.MARCH F/H INC. 1101 E. NORTH AVE.</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 10 1986</i>			
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

1. *[Faint, illegible handwritten text]*

2. *[Faint, illegible handwritten text]*

3. *[Faint, illegible handwritten text]*

4. *[Faint, illegible handwritten text]*

5. *[Faint, illegible handwritten text]*





00-02946

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10513

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
ERNEST		BURTON JR.		04		07		86	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE		NEGRO		09 07 53		32 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY	
Ohio		USA				BALTIMORE CITY		MD	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Mercy hospital		Housing Auth.					
14. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE	
Md.		n/a		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2312 St. Regis Ave. 21206	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Ernest		Joanne Turner		no		221-40-7481		Wilm., Del. 19805	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SPONTANEOUS INTRA CEREBRAL HEMORRHAGE 12 HRS		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN STREET		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 04/07/86 to 04/07/86 that (I) (we) last saw the deceased alive on 04/07/86, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
John F. Cary MD				04/07/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JOHN F. CARY MD		301 St. Paul St. Baltimore Md 21202							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
Burial		4/11/86		Gracelawn Cem.		New Castle		Del.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Leroy O. Dyett 4600 Lib. Hts. Ave.		APR 09 1986		John Davidson					

BP

100-100

Handwritten notes and markings on the right margin, including a large 'X' and some illegible text.

Main body of the document containing faint, mostly illegible text and markings. The text appears to be a series of lines or paragraphs, but the characters are too light to transcribe accurately. There are some faint numbers and symbols scattered throughout.

00-02490

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10514  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELLIE Marie Bush			2a. DATE OF DEATH MONTH DAY YEAR 4 2 86		2b. HOUR 12 <sup>45</sup> PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 24 14		6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7101 Martell Ave. / 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Martell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213/01/9930		17. INFORMANT ADDRESS Henry J. Bush-Old Road Bay Front/ Balto., Md. 21219	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>SUSPENS / DIC</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <u>4/1</u> , 19 <u>86</u> , to <u>4/2</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/2/86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.					
22b. SIGNATURE <i>Mark Eisner</i>		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK EISNER.		22e. ADDRESS FSK MC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/5/1986	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland 21222	
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc.		ADDRESS Balto., Md. 21222		25a. DATE REC'D. BY REGISTRAR APR 3 1986	25b. REGISTRAR'S SIGNATURE <i>John Darden</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ORDER NO. 100-100000

CHIEF



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be signed within a hour after death and returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be detached for the funeral director to use as the burial-transit permit. Then please remove cardiology and item 18 should be filed in the Min 72 hour after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10515  
REG NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JACK</b>		MIDDLE <b>E.</b>		LAST <b>BUSHMAN</b>		20. DATE OF DEATH MONTH DAY YEAR <b>APRIL 27, 1986</b>		21. HOUR HOURS MIN. <b>11:20A</b>	
1 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 10, 1919</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>66</b>		7b. HOUR HOURS MIN. <b>11:20A</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>baltimore city</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3202 Batavia Avenue 21214</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Norman F. Bushman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mayme Kline</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>WW 2</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret E. Bushman Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>15 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>									
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 27, 1986</b> , to <b>April 27, 1986</b> , that (I) (we) last saw the deceased alive on <b>April 27, 1986</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>4/27/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. M. GACIOCH</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 29, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gdns. of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 30 1986</b>			
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

25 14 121 0  
3 221 1 121 0

00-04491

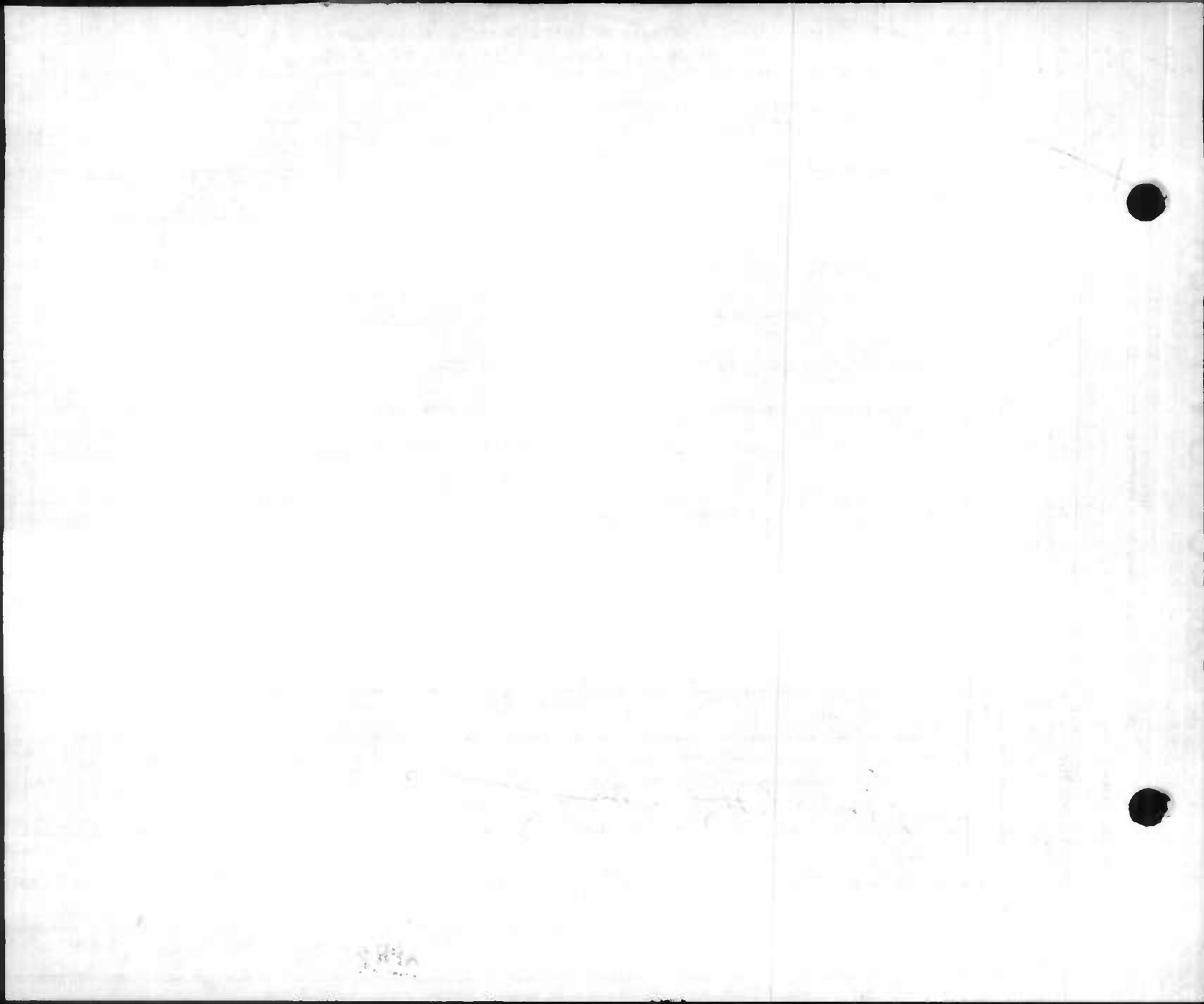
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MDHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10516	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Florence Butler										2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 4 20 19 86	
3. SEX F 4. RACE B 5. DATE OF BIRTH 11 5 22 6. AGE (IN YEARS) 63 YRS.										2b. HOUR M 8:27	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 7b. CITIZEN OF WHAT COUNTRY? U.S.A.										2c. DATE PRONOUNCED DEAD 4 20 19 86	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A	
12b. KIND OF BUSINESS OR INDUSTRY											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND 13b. COUNTY 13c. CITY OR TOWN BALTIMORE										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME UNKNOWN 15. MOTHER'S MAIDEN NAME LOUISE DIGGS										13e. STREET ADDRESS 2424 ARUNAH AVE. 21216	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 220-12-6297										17. INFORMANT ADDRESS GLORIA D. SMITH 117 VICTOR PARKWAY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Diabetes mellitus											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature] M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 4-20-86	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smith, M.D. ADDRESS 111 Penn St., Balt. MD. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 4-24-86 23c. NAME OF CEMETERY OR CREMATORY MOUNT AUBURN										23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME WM.C.MARCH F/H INC. ADDRESS 1101 E.NORTH AVE.										25a. DATE REC'D BY REGISTRAR APR 23 1986 25b. REGISTRAR'S SIGNATURE [Signature]	







0-04766

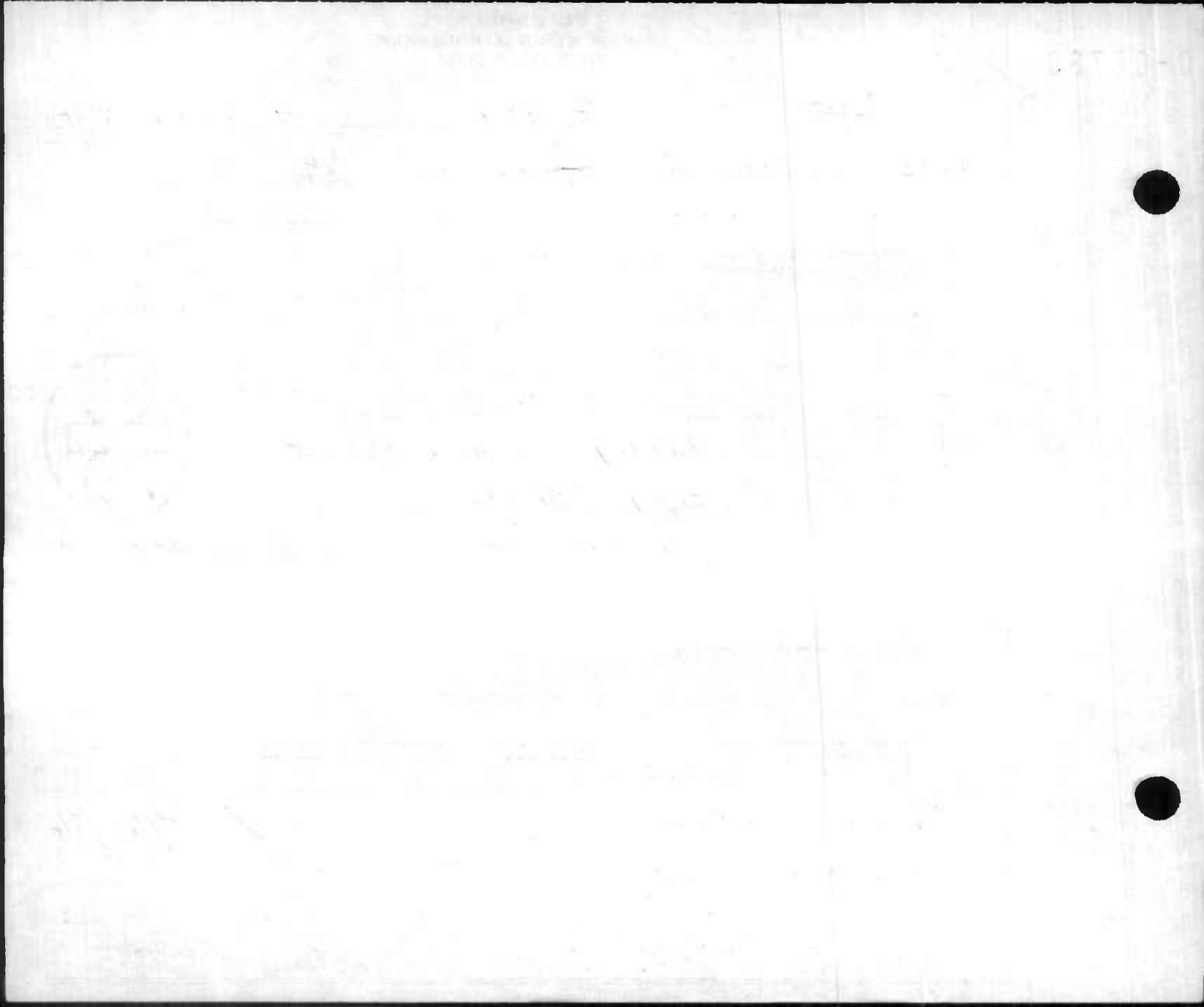
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>LEO - Butler Jr.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>4 23 86</b>					2b. HOUR <b>3:52P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 21 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER BALTIMORE MD</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CONSTRUCTION</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION CO</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4777 ELISON AVE. 21206</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEO BUTLER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNAE BRANDT</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 214 14 9891</b>		17. INFORMANT ADDRESS <b>J. LORRAINE BUTLER (WIFE) SAME ADDRESS</b>							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Septic shock</b>										<b>days</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>pneumonia</b>										<b>day-week</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from <b>March 17, 19 86</b> to <b>April 23, 19 86</b> that (X) (we) lost saw the deceased alive on <b>April 23, 1986</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.											
22b. SIGNATURE <b>Shayna Lee</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/23/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sheldon LEE</b>						22e. ADDRESS <b>3900 Loch Raver lvd. Baltimore Md 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>4/26/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>			
24. FUNERAL DIRECTOR <b>SCHIMONEK FUNERAL HOME, INC.</b> <b>3331 Brehms Lane, Balto. Md. 21213</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 25 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Jana Darden</b>			



00-02844

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10518

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROSA JAMES Butler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 02 '86</b>			2b. HOUR <b>12<sup>28</sup> PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 05 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Thompsville, W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>city</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARTIAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LAUNDRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PVT. FAMILIES</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Balto city</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>501 DOLPHIN ST. 904 BALTIMORE, MARYLAND 21201</b>	

14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE LEWIS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SALLIE UNKNOWN</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO.</b>		16b. SOCIAL SECURITY NO. <b>220-30-0953</b>	
17. INFORMANT <b>SUSIE KELLY</b>		ADDRESS <b>917- 13TH STREET WEST PALM BEACH, FLORIDA 33401</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several yrs.</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>HASCVD</b>		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22. I certify that (I) (this hospital) attended the deceased from **Apr 14**, 19 **83**, to **Apr 2**, 19 **86**, that (I) (we) last saw the deceased alive on **Apr 2**, 19 **86**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Myung H. Chung, M.D.</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/2/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Myung H. Chung, M.D.</b>		22e. ADDRESS <b>5670 B The Alameda, Balto, Md. 21239</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4/9/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEMORIAL PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>	
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24. FUNERAL DIRECTOR <b>Nutter &amp; Sons Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 08 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Susan K. ...</b>	
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

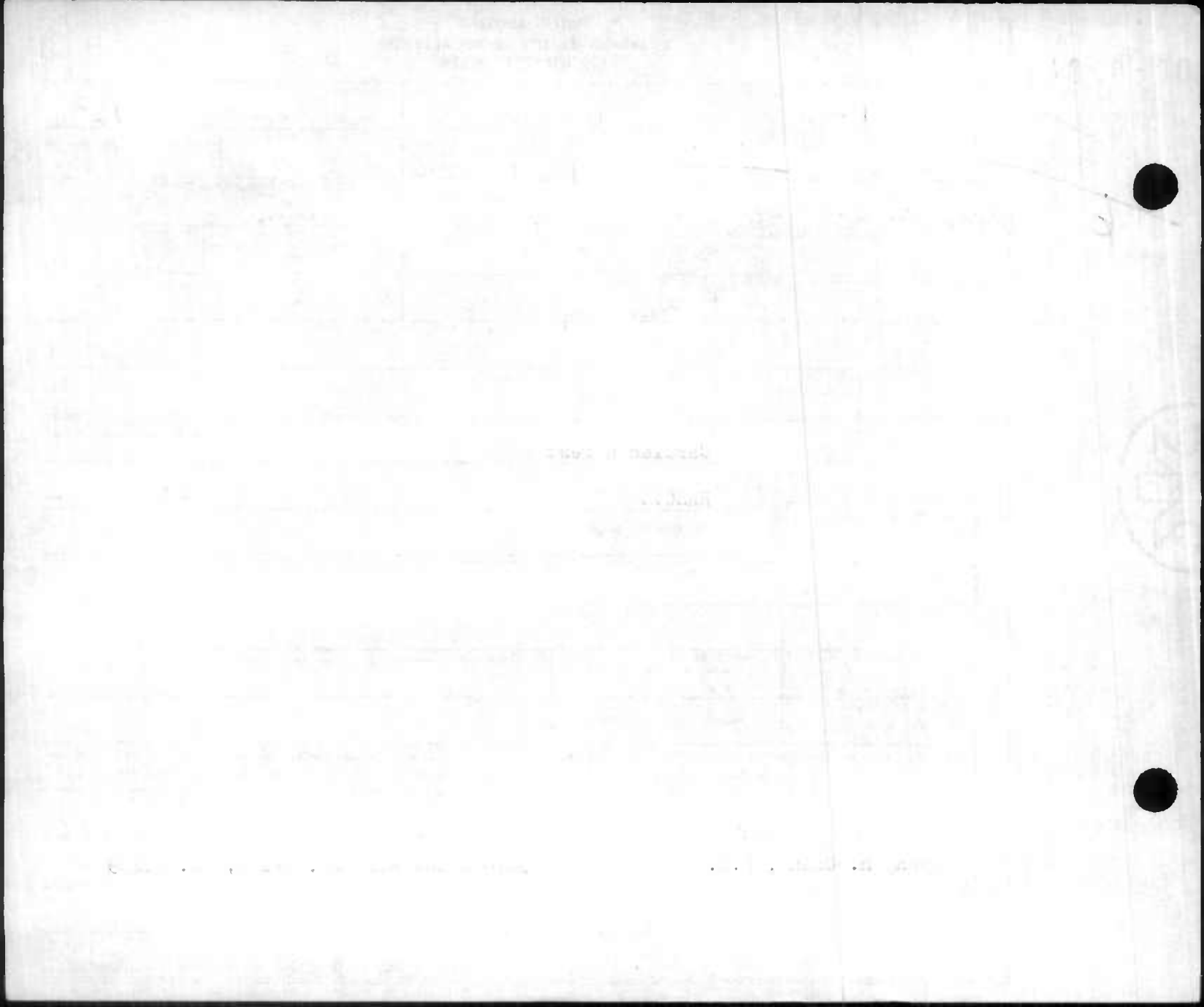
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified at the time of death.

MEDICAL CERTIFICATION

29

BP



00-03983

 FOR item 5, Film#G614-  
 1- STATE 4-30-86jlb  
 REGISTRAR

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

 8 6 1 0 5 1 9  
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ophelia Byrd			2a. DATE OF DEATH MONTH DAY YEAR April 14, 1986		2b. HOUR M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 9 14 12		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1826 N. Caroline Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST PHILLIP MOSES			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ISABELLE GIBSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-26-4606		17. INFORMANT ADDRESS FRANCES GIBSON 3645 ELMLY AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years longer</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> 19 <u>86</u> <u>July</u> to <u>April</u> 19 <u>86</u> , that (I) (we) lost <u>3/31</u> <u>19</u> <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <u>Steven M. Holland</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>4/14/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STEVEN M. HOLLAND</u>		22e. ADDRESS <u>JOHN HOPKINS HOSPITAL, BALTO 21205</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>4-19-86</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARBUTUS</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>ARBUTUS MARYLAND</u>
24. FUNERAL DIRECTOR NAME <u>March Funeral Homes 1101 East North Avenue</u>			25a. DATE REC'D. BY REGISTRAR <u>APR 18 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-03100

RECEIVED FROM

W. J. WILSON



00-04622

1- FOR  
STATE  
REGISTRAR

Item 13c per H.F.H. 4/28/86  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

10520

1. DECEASED NAME (TYPE OR PRINT) JOHN BARRETT CADOGAN			2a. DATE OF DEATH MONTH DAY YEAR 4 22 86			2b. HOUR 8:30 AM		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 2 6 13	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital		12a. USUAL OCCUPATION (TYPE OF EMPLOYMENT AND WORKING LIFE) Letter Carrier			12b. KIND OF BUSINESS OR INDUSTRY U.S. Postal Service		
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 911 John Ave. 21229				
14. FATHER'S NAME FIRST MIDDLE LAST John G. Cadogan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth A. Cunningham		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES				
16b. SOCIAL SECURITY NO. Ww II 705-03-9558		17. INFORMANT M. Adele Cadogan 911 John Ave. 21229						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic brain cancer DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: c								
19a. DATE OF OPERATION 3/31/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED bowel obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 3/29 1986 to 4/22 1986, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated								
22b. SIGNATURE Walter Reed MD		22c. DATE SIGNED 4/22/86		22d. ADDRESS 22 S. Greene St. Balt. MD 21209				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/25/86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen burnie A.A. Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		24b. ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR APR 24 1986		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





00-04002

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 0 5 2 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EUGENE CAMPBELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 16 86</b>		2b. HOUR <b>10 40 PM</b>		
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 19 40</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carriage Hill apts</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JIM HENRY PRESSLEY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOHANNE MAE CAMPBELL</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			
16b. SOCIAL SECURITY NO. <b>250-50-3579</b>		17. INFORMANT ADDRESS <b>Marguerite Campbell 2307 Winchester St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>hepatoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KMETZO</b>				22e. ADDRESS <b>Lutheran Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/21/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H West</b>				ADDRESS <b>4300 Wabash Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 18 1986</b>	
25b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

9  
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BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director must take it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified before.

100-1003

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00-04651

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMITS. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		6 REG. NO. 10522	
1 DECEASED NAME (TYPE OR PRINT) Francis D. Campbell		2a DATE KNOWN OF DEATH MONTH DAY YEAR 4 8 1986	
3 SEX MALE	4 RACE BLACK	5 DATE OF BIRTH (MONTH DAY YEAR) OCT. 10, 1929	6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? United States	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 611 Park Avenue	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman		12b KIND OF BUSINESS OR INDUSTRY private	
13a STATE Maryland		13b COUNTY Baltimore	
13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS 611 Park Avenue		21201	
14 FATHER'S NAME (FIRST MIDDLE LAST) CLARENCE CAMPBELL		15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) MABEL FARMER	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b SOCIAL SECURITY NO. 578 38 6220	
17 INFORMANT Cora Campbell-sister-1204 Walter St SE		ADDRESS Washington, D.C.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:45P 4/8 1986	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted gunshot wound			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home	
21f LOCATION CITY OR TOWN 611 Park Avenue, Baltimore, MD			
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE Gregory R. Kauffman, MD.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED 4/9/86	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4/14/86	
23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d LOCATION CITY OR TOWN Washington, D.C.	
24 FUNERAL DIRECTOR NAME ALEXANDER S. POPE-2617 Pa Ave., S.E. Wash., D.C.		25a DATE REC'D. BY REGISTRAR APR 22 1986	
25b REGISTRAR'S SIGNATURE John Davidson			

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100-10401-1000

100-10401-1000



0-04591

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				86 10523 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 4 21 86 2:25 PM			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mattie canedy				3. SEX Female			
4. RACE Black				5. DATE OF BIRTH 7/2/03 YEAR			
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.				7b. CITIZEN OF WHAT COUNTRY? USA			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Lutheran Hospital			
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY 13c. CITY OR TOWN Baltimore				12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			
14. FATHER'S NAME FIRST MIDDLE LAST Prince A. Ivey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Ivey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 239-32-6617			
17. INFORMANT Bessie Newkirk				ADDRESS 113 Wyche St. Roanoke Rapids, N.C. 27870			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest (b) DUE TO, OR AS A CONSEQUENCE OF MI (c) DUE TO, OR AS A CONSEQUENCE OF pos. Myocardial infarction							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION 4-15-86				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED C.S.I. bleeding			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				21d. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/21/86 to 4/24/86, that (I) (we) lost the deceased alive on 4/21/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE As usual				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Qureshi, MD				22e. ADDRESS Lutheran Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/26/86			
23c. NAME OF CEMETERY OR CREMATORY Crestview Mem. Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Roanoke Rapids, N.C.			
24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA				25a. DATE REC'D. BY REGISTRAR APR 24 1986			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson				25c. ADDRESS 1300 Eutaw Place			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-05397

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86		10524	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH						MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		LIONEL CARDONICK						APRIL 25, 1986		10:15 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. UNDER 1 YEAR		8. UNDER 24 HRS			
MALE		WHITE		1 15 41		45 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
PENNSYLVANIA		U.S.A.				BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		SETON HILL MANOR				SELF EMPLOYED		HAIRDRESSER					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
MARYLAND		MONTGOMERY		BETHESDA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6617 MICHAELS DRIVE 20817					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS					
JACK CARDONICK				JENNY OLENSKY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO				191-30-5214		EILEEN BENSON-GRIGG, FRIEND, SAME AS ITEM #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Immune Deficiency Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
										30 min.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u></u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED							
		HOUR A.M. MONTH DAY YEAR		P.M. 19		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)							
21f. INJURY OCCURRED		21g. PLACE OF INJURY		21h. LOCATION		21i. LOCATION							
WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-15</u> 19 <u>86</u> , to <u>4-25</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4-25</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE			
										DEGREE			
										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS			
JAMIE PUNZALAN										501 W FRANKLIN ST., BALTIMORE, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
CREMATION		4/26/86		METROPOLITAN CREMATORY		ALEXANDRIA, VIRGINIA							
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR			
RICHARD RAPP, INC. ST., N.W., WASHINGTON, D.C. 20009										25b. REGISTRAR'S SIGNATURE			
										MAY 2 1986			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

1827-10

1827-10

1827-10



00-03776

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO.

10525

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Margaret Carey</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>April 11, 1986</b>		2b. HOUR M <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 24 21</b>	
6. AGE IN YEARS (LAST BIRTHDAY) <b>64</b>		7. UNDER 1 YEAR MONTHS DAYS <b>7 5</b>		8. UNDER 24 HRS HOURS MIN. <b>1 0</b>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE MD</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3415 CROOKDALE AVE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME MAKER</b>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	
13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3415 CROOKDALE AVE 21216</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DEVON THORNTON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BESSIE WILLIAMS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. LONA HURD 1935 EMMERSON AVE 21223</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic renal insufficiency</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic renal insufficiency</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/6</b> , 19 <b>78</b> , to <b>3/18</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>3/18</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Julian J. J...</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/11/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Julian J. J...</b>		22e. ADDRESS <b>2435 W. Belvedere Ave, BA/Ho Md 21245</b>		22f. MEDICAL STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b>		23b. DATE <b>4-15-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN TUG MOUNT PK</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO CO MD</b>		24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ 2225 W. North Ave</b>			
25a. DATE RECD. BY REGISTRAR <b>APR 16 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



00-03582

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

10526

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GLADYS M. CARFINE			2a. DATE OF DEATH MONTH DAY YEAR 4 10 86		2b. HOUR 7:15pm
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 9 24		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO City MD	
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. CITY OR TOWN BALTO	13c. STREET ADDRESS / ZIP CODE 1415 Forest Park Ave 21207	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM SMITH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE WOOD Hood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN		16b. SOCIAL SECURITY NO. 21614 8843		17. INFORMANT Armond H. Carfine, Jr. - 1415 Forest Park Ave. #21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic ovarian carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 4-10 1986, to 4-10 1986, that (1) <del>was</del> lost saw the deceased alive on 4-10 1986, and that in my <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>was</del> (did) <del>not</del> view the body after death.					
22b. SIGNATURE Rosita R. Cruz		DEGREE M.D.		22c. DATE SIGNED 4/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rosita R. Cruz		22e. ADDRESS Bon Secours Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 14, 1986	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.
24. FUNERAL DIRECTOR NAME G. TRUMAN SUTWAB		5151 BALTO, NATL, PIKE # 21229		25a. DATE REC'D. BY REGISTRAR APR 15 1986	
25b. REGISTRAR'S SIGNATURE John D. ...					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of case.

xx

hospitals

also

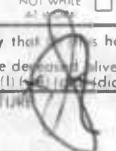
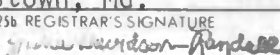
book

March 1, 1944 - 1945  
1946 - 1947

Mar. 22, 1944. New England Cemetery - 100.

APR 1 1944

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10527  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ARTHUR C. CARMICHAEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>04 03 86</b>			2b. HOUR <b>7:30 AM</b>				
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 15 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH CHURCH GREEN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1102 Druid Hill Ave. Apt. 907 21201</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Carmichael</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Thompson</b>			16. ADDRESS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-07-7553</b>		17. INFORMANT <b>Beatrice Hamer</b> ADDRESS <b>501 Dolphin St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>THORACIC and ABDOMINAL CARCINOMATOSIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA of PANCREAS</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Severe generalized atherosclerosis &amp; myocardial fibrosis/ischemia</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (s/he) (is/are) (hospital) attended the deceased from 19 to 19 that (he/she/it) last saw the deceased alive on 19 06 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE 						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/1/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR M. LEBOW</b>						22e. ADDRESS <b>3670 FORDS LANE RD. MD 21215</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4/8/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F.H West</b> ADDRESS <b>4300 Wabash Ave</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 08 1986</b>		25b. REGISTRAR'S SIGNATURE 		

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00-02593

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 5 2 8  
REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) Rodger Carnes		2a. DATE OF DEATH MONTH DAY YEAR 4/1/86		2b. HOUR 4:20 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 6 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asbestos Worker		12b. KIND OF BUSINESS OR INDUSTRY (Union) Local 11	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edwin Carnes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Holland		13e. STREET ADDRESS / ZIP CODE 3137 Kenyon Ave. 21213			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW II 220-01-2814		17. INFORMANT ADDRESS Irene Carnes (wife) same address			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Variceal Bleeding (Esophagus)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Liver Failure/Cirrhosis</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pulmonary Abscess</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/1/86</u> to <u>4/1/86</u> , that (I) (we) last saw the deceased alive on <u>4/1/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/1/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Timothy C. Trageser, M.D.		22e. ADDRESS Union Memorial Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/3/86		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR APR 04 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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NOV 21

11/21/00



NOV 21 11 21 AM '00





00-05276

FOR Film G615 item 18/22a

1- STATE REGISTRAR 5/27/86 rja

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

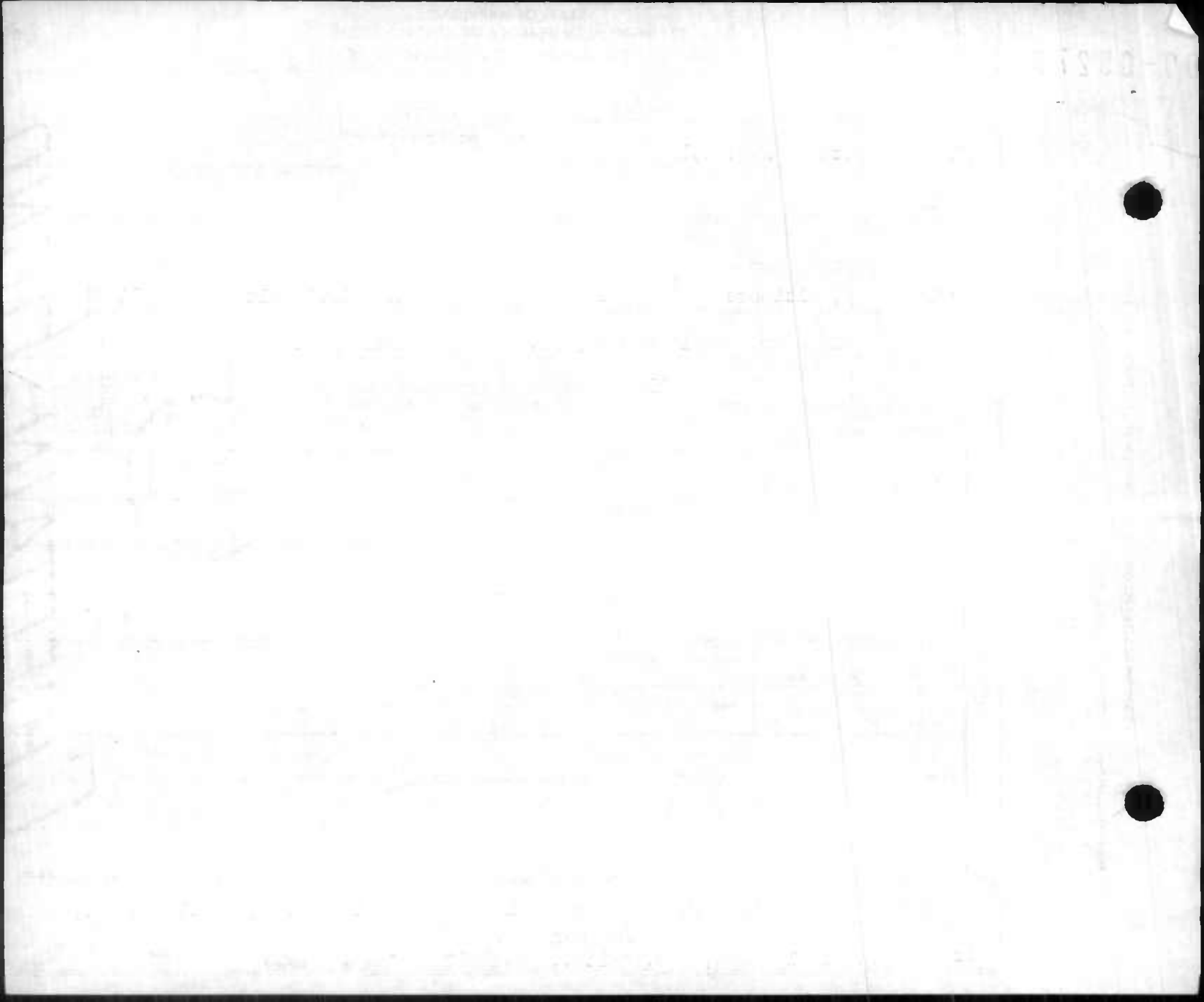
REG. NO. 10529

1. DECEASED NAME (TYPE OR PRINT) Blanchard DONALD Carney, Jr.			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 23 19 86			2b. HOUR M 1:18 P M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 4, 1948	6. AGE (IN YEARS) (LAST BIRTHDAY) 38 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 23 19 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland				13b. COUNTY Baltimore	13c. CITY OR TOWN Woodlawn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Blanchard Donald Carney, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Yost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-76-5809		17. INFORMANT ADDRESS Bradford Carney 474 Five Farms Lane Timonium, Md. 21093			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <u>Aspiration of Food</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:45 PM 4/23/ 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject Choked			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) Vocational Center		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 916 S. Rolling Rd. Catonsville Baltimore Co. Maryland			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 4-24-86	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth M.D.		ADDRESS 111 Penn St., Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Baltimore Co., Md.	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. Balto., Md. 21212		25a. DATE REC'D. BY REGISTRAR MAY 1 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MDHMH - 17  
(VR A15 ME (5))



00-04566

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

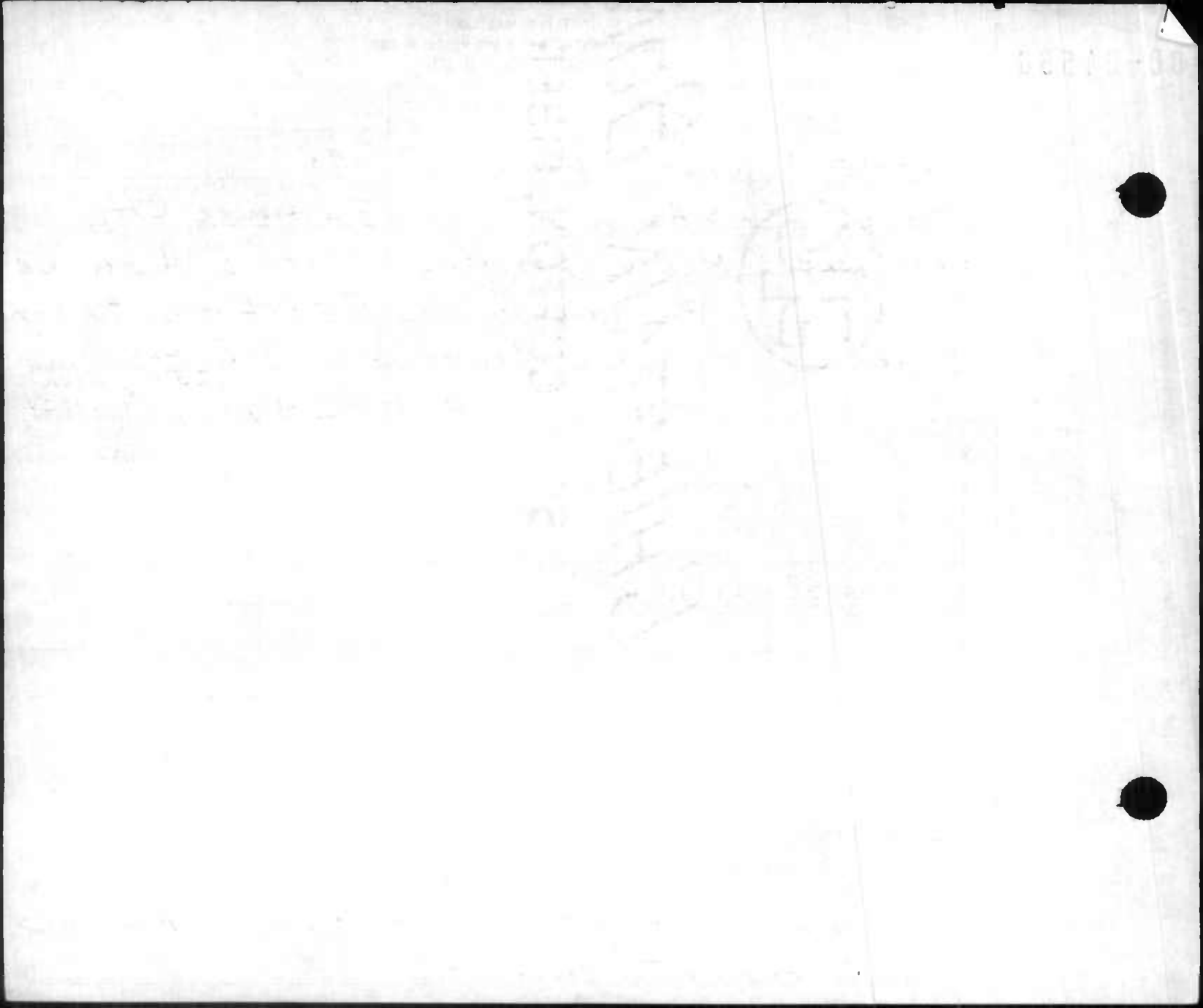
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
		DORA		M. CAROPPO		4		22 86		9 15 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 72 HRS	
FEMALE		White		May 16, 1907		78		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
ITALY		U.S.A.				BALTIMORE City				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		Mercy Hospital		Retired		Homemaker					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE							
Maryland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		125 S. EATON ST. 21224							
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)									
Domenic Micucci		Christina DiAugustino									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		220-03-3588		Mr. Giorgio Caroppo		125 S. EATON ST. 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart Failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (1) this hospital attended the deceased from 3/30 19 86 to 4/22 19 86 that (1) we last saw the deceased alive on 4/21 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (1) did (1) did not view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
Julie A. Mason MD						4/22/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Julie A. Mason M.D.		301 St. Paul Place Mercy Hosp. BALTO.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		4-25-86		GARDENS OF FAITH		BALTIMORE		Maryland			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Joseph N. ZANNINO JR.		APR 24 1986		[Signature]							



00-05729

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610531

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM CARPENTER</b>			2a. DATE OF DEATH <b>APRIL 18, 1986</b>			2b. HOUR <b>3:16 P</b> M		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 2 41</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Elkton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>157 High St. 21921</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Carpenter</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mae Peterson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unkn.</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>141309971</b>		17. INFORMANT ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Neurofibromatosis</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (i) this hospital attended the deceased from <b>4/18/86</b> , 19____, to <b>4/18/86</b> , 19____, that (ii) I saw the deceased alive on <b>4/18/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.								
22b. SIGNATURE <b>Jonathan Israel</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/18/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JONATHAN ISRAEL</b>					22e. ADDRESS <b>600 N. Wolfe St Baltimore Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>4-21-86</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 05 1986</b>			
ADDRESS <b>Balto., Md.</b>					25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate is to be completed by the attending physician or hospital official. It should be completed and filed with the hospital records. It should be detached for use on the State Department of Health and Mental Hygiene form. It should be filed with the State Department of Health and Mental Hygiene form. It should be filed with the State Department of Health and Mental Hygiene form.

BP

DHMH-16-50M (1/81)  
(VRA 15, 4)

0555



PL 04-055  
18,500,000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				86 10532 REG. NO.			
<b>Item 4</b> FOR STATE REGISTRAR A.L. 4-25-86 per phone							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST LUVENENIA C. CARR.				MONTH DAY YEAR 4/7/86		3:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE	Black	MONTH DAY YEAR 10 31 51		34 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD.	US.			BALT. CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO	BON SECOURS HOSP.						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
MD.		BALTO		218 N. AUBURN ST. BALTO 21223			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
WM. SCOTT		ROSETTA FERGUSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		217-56-9564		ROSETTA LIFSEY 8244 BOOTH ST. BALTO MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gastric Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 mos</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>P. Kanto</u> DEGREE _____		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/9/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>P. Kanto</u>		22e. ADDRESS _____					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>4-11-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR NAME <u>BROWN THOMPSON F.H.</u> ADDRESS <u>1913 W. BALTO. ST</u>				25a. DATE REC'D. BY REGISTRAR <u>APR 15 1986</u>		25b. REGISTRAR'S SIGNATURE <u>John Thompson</u>	

100733-10

20X COLLOIDAL SILVER



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				86 10533 REG. NO.			
1. STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 4-6-86 10 A.M.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE J. LAST Carr				2b. HOUR			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 10, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jessup, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key med. center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg.	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Frank MIDDLE LAST Tauber		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST Weigartner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-07-0208	
17. INFORMANT Baltimore, Md. 21205.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Death Cardiovascular		19. DATE OF OPERATION 3/13/86		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) after operation for cholecystitis, cholelithiasis		22. SIGNATURE W. E. Moran		22c. DATE SIGNED 4/6/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 9, 1986		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE	
24. FUNERAL DIRECTOR John A. Moran, Inc. Funeral Home		25. DATE REC'D. BY REGISTRAR APR 11 1986		26. REGISTRAR'S SIGNATURE		27. ADDRESS Johns Hopkins Hospital	



0-03770

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10534  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST May Alice Carter			2a. DATE OF DEATH MONTH DAY YEAR 4 13 1986		2b. HOUR 5:50 AM
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 05 01 99		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) Lutheran Hosp.		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1910 W. Sanctuary St. 21223	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Margaret Holland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-20-5083		17. INFORMANT ADDRESS William E. Drayton 1110 Lyndhurst St.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cancer of stomach and Metastasis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/13 1986 to 4/13 1986, that (I) (we) lost saw the deceased alive on 4/13 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE R. Girgis M.D.	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 4/13/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raafat Y. Girgis		22e. ADDRESS Lutheran Hospital - Baltimore	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/17/86	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	23d. LOCATION CITY OR TOWN COUNTY Baltimore MD
24. FUNERAL DIRECTOR NAME William C. March F/H West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR APR 16 1986	25b. REGISTRAR'S SIGNATURE John S. ...

0520-0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610535  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Naomi MIDDLE: A. LAST: Carter		2a. DATE OF DEATH MONTH: 4 DAY: 19 YEAR: 86		2b. HOUR 7:36 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH: 11 DAY: 10 YEAR: 23		6. AGE (IN YEARS (LAST BIRTHDAY)) 62 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY Public Schools
13a. STATE MD	13b. COUNTY MCH	13c. CITY OR TOWN Chen Burnie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1414 Valentine Ave 21061
14. FATHER'S NAME FIRST: Douglass MIDDLE: LAST: Knox		15. MOTHER'S MAIDEN NAME FIRST: Minnie MIDDLE: LAST: Crippen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-20-6886		17. INFORMANT Elmer T. Carter 1414 Valentine Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Elmer T. Carter, MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-19-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor Hrehorovich		22e. ADDRESS 3001 S. Hanover		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-25-86	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION CITY OR TOWN: Anne Arundel Co. COUNTY: MD STATE: MD
24. FUNERAL DIRECTOR NAME: W. C. March 4300 Whitcomb Ave.		25a. DATE REC'D. BY REGISTRAR APR 23 1986		

MEDICAL CERTIFICATION



00-04921

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

10536

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GEORGE B CASSIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 25 86</b>		2b. HOUR <b>8:15A M</b>		
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 26 19</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>66</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY OF MD. HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturers Rep.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DEMETRE CASSIS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELLEN - CASSIS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>yes WW 2</b>			
16b. SOCIAL SECURITY NO. <b>220-03-5392</b>		17. INFORMANT <b>Mrs. Viola Cassis</b>				ADDRESS <b>Same</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Diffuse Undifferentiated Lymphome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acquired Immunodeficiency Syndrome</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Coronary artery disease</b>							
19a. DATE OF OPERATION <b>4/3/86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Lymphome</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>CPR Belani MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHANDRA PRAKASH BELANI</b>				22e. ADDRESS <b>UMCC, 22 S. Green Street Baltimore MD 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 28, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 28 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

*[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side.]*



00-037900

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10537  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JUDITH H. CASTELLI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 13, 1986</b>		2b. HOUR <b>1:48P M</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 4 1950</b>		
6. AGE (IN YEARS (LAST BIRTHDAY)) <b>35</b> YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Counselor</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Emy</b>		13a. STREET ADDRESS <b>746 Dividing Road 21146</b>		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Larry Martin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Deena Werner</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>095-38-2905</b>		17. INFORMANT ADDRESS <b>Vincent Castelli Same as #13</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ZERO</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>PRESUMED SEPSIS</b>				<b>1 DAY.</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>PAROXYSMAL NOCTURNAL HEMOGLOBINURIA</b>				<b>21 YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>COMA, HYPERAMMONEMIA, SPLENECTOMY, MULTIPLE THROMBOSES IN PAST</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 12</b> 19 <b>86</b> , to <b>APRIL 13</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>APRIL 13</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>John G. Sotos</b>		DEGREE		22c. DATE SIGNED <b>4/14/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John G. Sotos</b>		22e. ADDRESS <b>Johns Hopkins Hospital</b>		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>04-15-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto. Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Cremation Society of Md. Inc. Maryland</b>			
25a. DATE REC'D. BY REGISTRAR <b>APR 16 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Hordell</b>			

DIVISION OF VITAL RECORDS, 500 W. WISCONSIN ST., BALTIMORE, MARYLAND 21201  
155-38-60-1  
CASTELLI, JUDITH H.  
TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as above, 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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00-02494

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, does any injury, or other traumatic event, a medical examiner must be notified.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10538  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES EDGAR CATHER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 3 86</b>				2b. HOUR <b>8:30AM</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 06, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Lansdowne</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>2406 Alma Road 21227</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert E. Cather</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Gobel</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-05-9481</b>		17. INFORMANT ADDRESS <b>Ruby F. Cather 2406 Alma Road 21227</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cerebral ischemia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>cardiovascular insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>squamous cell carcinoma of tongue.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>A. Maciulis</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>04/03/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. MACIULIS</b>				22e. ADDRESS <b>St. Agnes Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>04/05/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Howard Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ambrose Funeral Home 1328 Sulphur Spring Road</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 03 1986</b>		25b. REGISTRAR'S SIGNATURE <i>Frederick R. Rouse</i>			

BP

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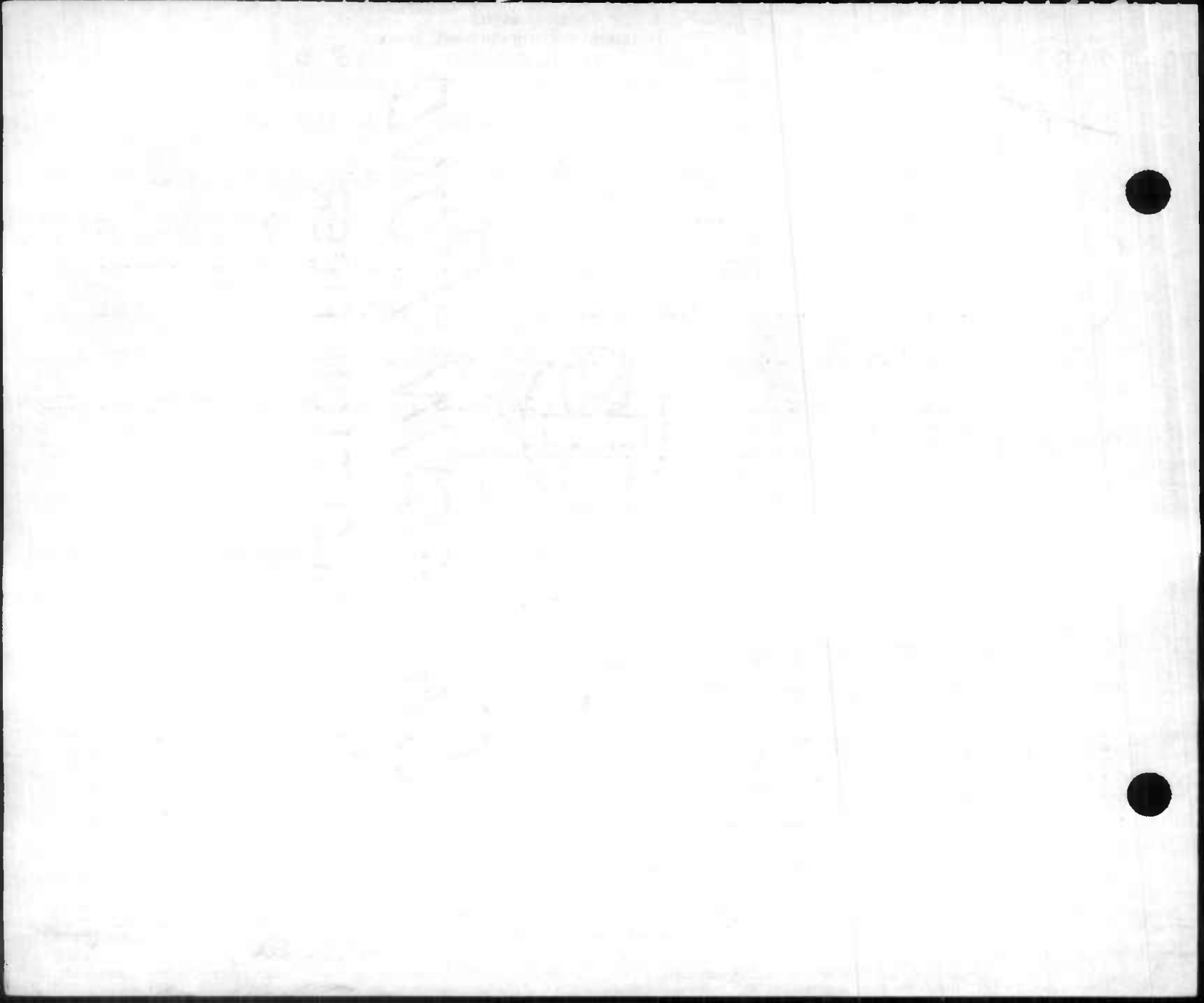
1014 1014 1014

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00-02457

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10539  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GORDON THOMAS CHAMBERS, JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 1, 1986</b>		2b. HOUR <b>1:45a M</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 12 29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>1 0 5</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Project Admin.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>D.M.J.M.</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1133 McHenry Drive 21061</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gordon T. Chambers, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Thomas</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>Korean 217-26-1360</b>		17. INFORMANT <b>Charlotte L. Chambers 1133 McHenry Dr. 21061</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ARRHYTHMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIOMYOPATHY</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 16, 19 86</b> to <b>APRIL 1, 19 86</b> , that <b>xx</b> (we) lost saw the deceased alive on <b>April 1, 19 86</b> , and that in <b>xxx</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>xx</b> (we) (did) <b>xxx</b> (not) view the body after death.						
22b. SIGNATURE <b>William Tan MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/1/86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM TAN MD</b>		22e. ADDRESS <b>C/O Maryland General Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4/4/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>		ADDRESS <b>21229 4107 Wilkens Ave.</b>		25a. DATE REC'D BY REGISTRAR <b>APR 3 1986</b>		



00-02830

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0540

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
JOHN		Edward		CHAMBERS				4		3		1986				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	8 28 25		24 6		MONTHS		DAYS		4		3		1986		7:23 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.A.		WIDOWED		DIVORCED		Baltimore City								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		19 N. Schroeder St.		N/A													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19 N. Schroeder Street 21223									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
John		Isabelle															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		220-14-0628		Annie Hall		19 N. Schroeder Street											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Dennis F. Smyth, M.D.		Assistant		4-3-86													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Dennis F. Smyth, M.D.		111 Penn St., Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
BURIAL		4/7/86		Garrison Forest Veteran		Owings Mills		Md.									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REG. CLERK		25b. REG. CLERK SIGNATURE											
March Funeral Homes		1101 East North Avenue		APR 07 1986													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS PM 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))





00-03068

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 5 4 1  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL CHARLESTON</b>			2a DATE OF DEATH MONTH DAY YEAR <b>4 2 86</b>			2b HOUR <b>7 24 PM</b>			
3 SEX <b>Female</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10 07 1985</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>5 26</b>		IF UNDER 1 YEAR MONTHS DAYS <b>5 26</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD</b>			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INFANT</b>		12b KIND OF BUSINESS OR INDUSTRY <b>—</b>	

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>MD BALTIMORE</b>		13b CITY OR TOWN <b>BALTIMORE</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>4224 COLBORNE RD 21229</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>BRIAN BAILEY</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHEY L. CHARLESTON</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			
16b SOCIAL SECURITY NO.			17 INFORMANT <b>Jo Bryant Bailey</b>			ADDRESS <b>412 Ilchester Ave 21218</b>			

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC + RESPIRATORY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) <b>HYDROCEPHALUS 2° TO IVH, BPD</b>	
DUE TO, OR AS A CONSEQUENCE OF		(c) <b>PREMATURITY</b>	

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **—**

19a DATE OF OPERATION <b>2-11-86</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>HYDROCEPHALUS</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>—</b>					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>		22a I certify that (I) (this hospital) attended the deceased from <b>10-07</b> , 19 <b>85</b> , to <b>4-2</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>4-2</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b SIGNATURE <b>Janice L. Dec</b>				DEGREE <b>MD</b>		22c DATE SIGNED <b>4-2-86</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JANICE L. DEC</b>				22e ADDRESS <b>ST. AGNES HOSP. 900 CATON AVE BALT 21229</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b DATE <b>April 4'86</b>		23c NAME OF CEMETERY OR CREMATORY <b>Westview Memorial Pk.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto., Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Harry H Witzke &amp; Family Funeral Home</b>				25a DATE REC'D. BY REGISTRAR <b>APR 11 1986</b>		25b REGISTRAR'S SIGNATURE <b>John Davidson-Rodale</b>	
Inc. 4112 Old Columbia Pike Ellicott City							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be examined by a physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please return this certificate, pages 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of pronouncement. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-04440

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10542  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LENA BLANCHE CHASSON			2a. DATE OF DEATH MONTH DAY YEAR APRIL 16, 1986		2b. HOUR 3:30A. M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR APRIL 14, 1900	6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3809 CLARKS LA, APT. 307 (21215)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3809 CLARKS LA, APT. 307 (21215)	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL NESSEL	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINDEL SALIS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 217-20-8607		17. INFORMANT DR. DANIEL M. CHASSON 3809 CLARKS LA, APT. 307 21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC LUNG CANCER</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>ASCVD, ANEMIA</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>APR 7 1986</u> to <u>4/16 1986</u> , that (I) (we) last saw the deceased alive on <u>APR 7 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>GAM</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>4/17/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GAM</u>	22e. ADDRESS <u>711 W. 40TH ST.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4/17/86	23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	23e. DATE REC'D. BY REGISTRAR APR 23 1986	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215		25a. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodriguez</u>			

BP \_\_\_\_\_



Handwritten text, possibly a signature or date, including the word "April" and "1904".

00-04915

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8610543

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGIA A. CHATTIN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4 26 86</b>		2b. HOUR <b>430 P M</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 30, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>		10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>Md.</b>		12b. CITY OR TOWN <b>Baltimore</b>		12c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
12d. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Pickens</b>		12e. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgia Mae Wienold</b>		12f. STREET ADDRESS / ZIP CODE <b>8703 Old Harford Road 21234</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		14. SOCIAL SECURITY NO <b>411-34-8386</b>		15. INFORMANT <b>Mr. Jack O. Chattin Same</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: } (b) <b>non-Hodgkin's Lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4-25</b> 19 <b>86</b> to <b>4-26</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>4-28</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Janine L. Good</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4-26-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JANINE L. GOOD M.D.</b>		22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>April 28, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial</b>	
23d. LOCATION (CITY OR TOWN) <b>Catonsville</b>		COUNTY <b>Balto.</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 28 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>	

VIETNAM • AIDKORC

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YTD 2005

UNION MEMBERS WANTED

## ACKNOWLEDGMENTS

400

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10544

REG. NO.

1- FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
*Nudia Chatzky*

2a. DATE OF DEATH MONTH DAY YEAR  
*4-14-86* 7b. HOUR  
*7:45 PM*

3 SEX *FEMALE* 4 RACE *WHITE* 5. DATE OF BIRTH MONTH DAY YEAR  
*9 / 15 / 1938* 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.  
*47* *102* *RS*

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) *RUSSIA* 7b. CITIZEN OF WHAT COUNTRY? *USA* 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH  
*BALTIMORE CITY* MD.

10. CITY OR TOWN OF DEATH *BALTO* 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
*LEVINDALE AGED HOME* 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
*HOUSEWIFE* 12b. KIND OF BUSINESS OR INDUSTRY  
*AT HOME*

13a. STATE *MARYLAND* 13b. COUNTY *BALTO* 13c. CITY OR TOWN *OWINGS MILLS* 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE  
*4 SIERRA CIRCLE, APT. E 21117*

14. FATHER'S NAME FIRST MIDDLE LAST  
*Simcha GINSBERG* 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
*RACHEL unknown*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) *NO* 16b. SOCIAL SECURITY NO. *219-01-0788* 17 INFORMANT ADDRESS  
*PHILIP CHATZKY 6968 BROOKMILL RD. APT. 1C 21215*

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *ESOPHAGEAL CANCER*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*3 mo*Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) *—*

DUE TO, OR AS A CONSEQUENCE OF

(c) *—*PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *—*

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
*19* 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from *—*, 19 *—*, to *—*, 19 *—*, that (I) (we) last saw the deceased alive on *—*, 19 *—*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE *[Signature]* DEGREE *MD* ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 22c. DATE SIGNED  
*4-15-86*

22d. PHYSICIAN'S NAME (TYPE OR PRINT) *AJ Weiss MD* 22e. ADDRESS  
*2434 W BELVEDERE AVE BALTO MD 21215*

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) *BURIAL* 23b. DATE *4/17/86* 23c. NAME OF CEMETERY OR CREMATORY *SHOMREI MISHMERES CEM* 23d. LOCATION CITY OR TOWN COUNTY STATE  
*ROSEDALE BALTO MD.*

24. FUNERAL DIRECTOR NAME *SOL LEVINSON & BROS., INC.* ADDRESS *6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215* 25a. DATE REC'D. BY REGISTRAR *APR 23 1986* 25b. REGISTRAR'S SIGNATURE *[Signature]*

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00-05356

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10545	
1- FOR STATE REGISTRAR											
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Norman Chester										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 4/ 29/19 86	
1 SEX M 4 RACE B 5 DATE OF BIRTH MONTH DAY YEAR 1 16 96 6 AGE (IN YEARS) (LAST BIRTHDAY) 90 YRS.										7b. HOUR M 2:57 P M	
7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4/ 29/19 86										7d. HOUR P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 7b. CITIZEN OF WHAT COUNTRY? U.S.A.										9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
10 CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1521 N. Spring St.										12a. USUAL OCCUPATION (TYPE OF WORK FORMER OR WORKING LIFE) N/A	
12b. KIND OF BUSINESS OR INDUSTRY											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND 13b. COUNTY 13c. CITY OR TOWN BALTIMORE										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1521 N. SPRING ST. 21213											
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT CHESTER										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELLEN LEE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 216018437A										17. INFORMANT ADDRESS 1521 N. SPRING BLONDIENE MARGARET CHESTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. Assistant										DATE SIGNED 4/30/86	
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 5-2-86										23c. NAME OF CEMETERY OR CREMATORY MOUNT AUBURN	
23d. LOCATION CITY OR TOWN BALTIMORE COUNTY MARYLAND											
24. FUNERAL DIRECTOR NAME ADDRESS WM.C.MARCH F/H INC. 1101 E.NORTH AVE.										25a. DATE REC'D. BY REGISTRAR MAY 1 1986	
25b. REGISTRAR'S SIGNATURE [Signature]											

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(VR A15 ME (1))

PAGE NO. 11

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1/10/11

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

B 6 1 0 5 4 6

1. DECEASED NAME (TYPE OR PRINT) <b>Richard A Chestnut</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 22 86</b>			2b. HOUR <b>11:20 P.M.</b>			
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 12 44</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY,</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANCIS SCOTT KEY MEDICAL CTR.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					12131				
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1732 E. FAYETTE STREET</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN RICHARDSON</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>THELMA JORDAN</b>			ADDRESS <b>Chester, Pa. 19013</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>172-34-8999</b>		17. INFORMANT ADDRESS <b>Thelma Jordan 1430 West 2nd Street</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>4.10.86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Low Back Pain</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4.7.86</b> to <b>4.22.86</b> , that (I) (we) last saw the deceased alive on <b>4.22.86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Richard Chen</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>4.22.86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Chen</b>				22e. ADDRESS <b>4440 Eastern Ave Baltimore, MD 21224</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4/29/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest VA</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Owings Mills, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>March Funeral Homes 1101 East North Avenue</b>					25a. DATE REC'D. BY REGISTRAR <b>APR 28 1986</b>				
					25b. REGISTRAR'S SIGNATURE <b>Jane Carson</b>				

MEDICAL CERTIFICATION

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(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, and 3 and 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2, and affix them to the back of the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8610547  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Suzanne Gibbons Childs</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>04 11 86</b>		2b. HOUR <b>7:29 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 10 15</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		8. IF UNDER 24 HRS HOURS MIN. <b>YRS</b>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city MD.</b>		
12. CITY OR TOWN OF DEATH <b>Baltimore</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland Hosp.</b>		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE <b>MD</b>		15b. COUNTY <b>Worcester</b>		15c. CITY OR TOWN <b>Baltimore</b>		
16. FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b>		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>		18. STREET ADDRESS & ZIP CODE <b>105 Boston Dr. 21811</b>		
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		20. SOCIAL SECURITY NO. <b>215-16-5678</b>		21. INFORMANT <b>hospital admitting.</b>		
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>severe coronary artery disease</b>					?	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerosis</b>					?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
23a. DATE OF OPERATION <b>4/7/86</b>		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>coronary artery disease</b>		24. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		27. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
28. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		29. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		30. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4/7/86 4/11/86</b>		
31. I certify that (I) (this hospital) attended the deceased from <b>4/7/86</b> , 19____, to <b>4/11/86</b> , 19____, that (I) (we) last saw the deceased alive on <b>4/11/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
32. SIGNATURE <b>Jack Flowers MD.</b>				33. DATE SIGNED <b>4/11/86.</b>		
34. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jack Flowers MD.</b>				35. ADDRESS <b>22 S Green St Balt MD 21201.</b>		
36. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		37. DATE <b>April 16, 1986</b>		38. NAME OF CEMETERY OR CREMATORY <b>Baldwin Memorial</b>		
39. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel</b>		40. ADDRESS <b>Annapolis MD</b>		41. 25a. DATED BY REGISTRAR <b>4/17/86</b>		
42. 25b. REGISTRAR'S SIGNATURE						

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

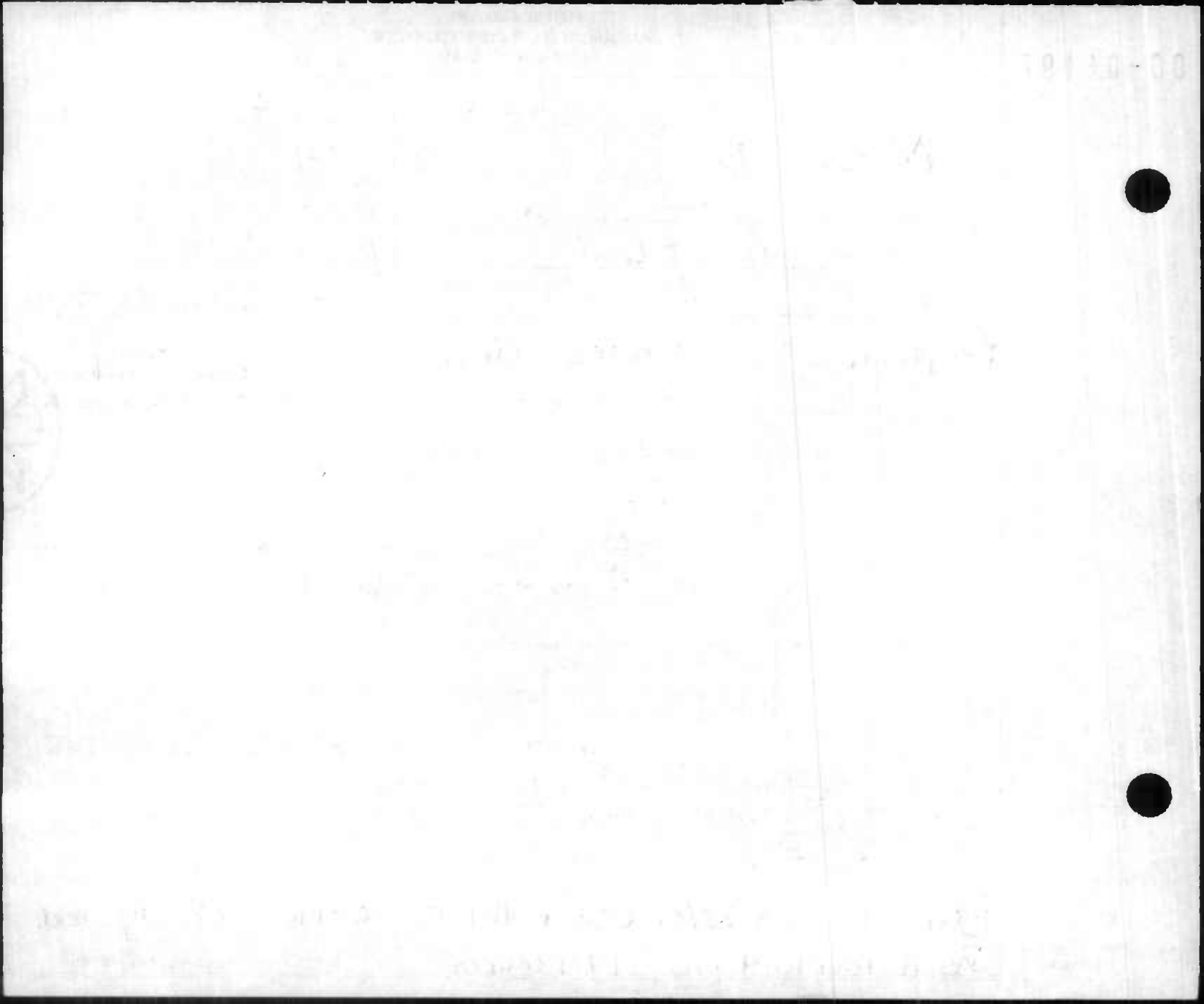
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 86 10548

1. DECEASED NAME (TYPE OR PRINT) <b>Anthony Chiles</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 19 86</b>				2b. HOUR <b>06 30 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 06 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mason F Lord</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5200 Eastern Ave 21224</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin Chiles</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann Gray</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>227014664</b>		17. INFORMANT ADDRESS <b>Records Laurie Edwards 308 Lorraine ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Decubiti</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Comatose 4 wks, Diabetes, GI bleeding, pneumonia</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4-18 86</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-17 86</b> to <b>4-19 86</b> , that (I) (we) last saw the deceased alive on <b>4-18 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Hartmut A. Doerwaldt MD</b>		DEGREE		22c. DATE SIGNED <b>4-21-86</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hartmut A. Doerwaldt</b>			
22e. ADDRESS <b>120 S. Greene St / Baltimore</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/25/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedee Hill Cem Balto</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County MD</b>			
24. FUNERAL DIRECTOR NAME <b>Jas. A. Morton &amp; Sons</b>		ADDRESS <b>1701 Lauren</b>		25a. DATE REC'D BY REGISTRAR <b>APR 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodden</b>			





0-03656

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1-2, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10549	
1- FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) <b>ROBERT CHISLEY</b>										2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>4 10 1986</b>	
3 SEX <b>MALE</b> 4. RACE <b>BLACK</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>May 9, 1919</b> 6. AGE (IN YEARS) (LAST BIRTHDAY) <b>67 YRS.</b>										7b. HOUR <b>M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b> 7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4 10 1986</b> 2d. HOUR <b>2:50 PM</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.											
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CEMENT FINISHER</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>PRIVATE</b>											
13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>CHARLES</b> 13c. CITY OR TOWN <b>NEWBURG</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>ROUTE 1 BOX 3N/ 20664</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>RUFUS M. CHISLEY</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DELLA E. HILL</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO. <b>214-12-7725</b>	
17. INFORMANT ADDRESS <b>Bernice Chisley Newburg, Maryland</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Ann M. Dixon</b> M.D. <b>Assistant</b> MEDICAL EXAMINER										DATE SIGNED <b>4-11-86</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b> ADDRESS <b>111 Penn St., Balto., MD 21201</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>										23b. DATE <b>4-16-86</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH CHURCH</b>										23d. LOCATION <b>POMFRET CHARLES MD.</b>	
24. FUNERAL DIRECTOR NAME <b>THORNTON FUNERAL HOME</b> ADDRESS <b>POMONKEY, MD.</b>										25a. DATE REC'D. BY REGISTRAR <b>APR 15 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>											

MEDICAL CERTIFICATION

00000-0



00-04535

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8610550	
1. DECEASED NAME (Type in print) FIRST MARY MIDDLE CHORNYEI LAST						2a. DATE OF DEATH MONTH 4 DAY 22 YEAR 86		2b. HOUR 10 <sup>03</sup> PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 2 YEAR 1892		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore 6				12a. USUAL OCCUPATION (TYPE OF BUSINESS OR WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. STATE Maryland						13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST Leopold MIDDLE Szocek LAST						15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Bensich LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 705-03-9498		17. INFORMANT Mary Chornyei, 2321 W. Patapsco Ave., 21230							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Intestinal Obstruction											
19a. DATE OF OPERATION 4/21/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostatectomy				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/20/86, 19, to 4/22/86, 19, that (I) (we) lost saw the deceased alive on 4/22/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. Calderon				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/22/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Calderon, M.D.						22e. ADDRESS South Baltimore General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/25/86		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,				ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR APR 24 1986		25b. REGISTRAR'S SIGNATURE			

BP



00-03984

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10551

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
Mary			ELIZABETH			Christian			X MONTH DAY YEAR			M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR.		
F			B			10 5 17			68 YRS.			MONTHS DAYS HOURS MIN.		
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND			U.S.A.			WIDOWED X			DIVORCED			Baltimore City MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			Johns Hopkins Hospital			MARYLAND UNIV.			COLLEGE					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MARYLAND						BALTIMORE			YES X NO			2014 ASHLAND AVE. 21205		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
HENRY			HAMMON			MARY			BURGUSS			ADDRESS		
16a. NO			16b. 219-22-3503			17. DOROTHY BROWN			2010 ASHLAND AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b)														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I														
Diabetes														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
												YES NO X		
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
				P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry X and in my opinion death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED						
Dennis F. Smyth, M.D.				Assistant MEDICAL EXAMINER				4-17-86						
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn St., Balto., MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL				4-21-86		EVANS CHAPEL CEM.				COOKSVILLE MARYLAND				
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
WM.C.MARCH F/H INC.				1101 E.NORTH AVE.				APR 18 1986				Hendell		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP

DHMH - 17  
(VR A15 ME (1))

COLLON 1.35x

22.0



11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following pages 7 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical examiner must be notified by phone.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MALE CLARK</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>04-25-86</b>		2b. HOUR <b>10<sup>59</sup> AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 25 86</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INFANT</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>Brookly</b>		13c. CITY OR TOWN <b>Balto</b>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOANN CLARK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PREMATURITY</b> (≈ 18 weeks gestation) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8<sup>00</sup> PM 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>4/25/86 8<sup>00</sup> PM</b> to <b>4/25/86 10<sup>59</sup> PM</b> , that (1) (we) last saw the deceased alive on <b>4/25/86 10<sup>59</sup> PM</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Judith L. Chipman</b>		DEGREE <b>MD</b>		22c. DATES SIGNED <b>4/25/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JUDITH L. CHIPMAN</b>		22e. ADDRESS <b>3001 S. Hanover ST.</b>		22f. CITY OR TOWN <b>S. Balt. Gent's</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>5-1-86</b>		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 05 1986</b>	
				25b. REGISTRAR'S SIGNATURE <b>Judith L. Chipman</b>	

BP

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00-03032

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10553  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES Marshall Clark</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 8, 1986</b>				2b. HOUR <b>12:13PM</b>	
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 24 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY MD</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4005 ELKADER RD. 21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY CLARK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>232-26-2853</b>		17. INFORMANT ADDRESS <b>DOROTHY M. COTTON 4005 ELKADER RD.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>sudden death acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <b>Demetia</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 85</b> to <b>April 86</b> , that (I) (we) last saw the deceased alive on <b>Jan 31 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Susan Denman M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>4/9/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Susan Denman</b>				22e. ADDRESS <b>5200 Eastern Ave</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4-11-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKHILL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MOOREFIELD W. VIRGINIA</b>			
24. FUNERAL DIRECTOR NAME <b>WM.C.MARCH F/H INC. 1101 E.NORTH AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 09 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Felia Davidson-Randall</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician or attending physician must sign the certificate and retain it for 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The physician or attending physician must sign the certificate and retain it for 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **10554**

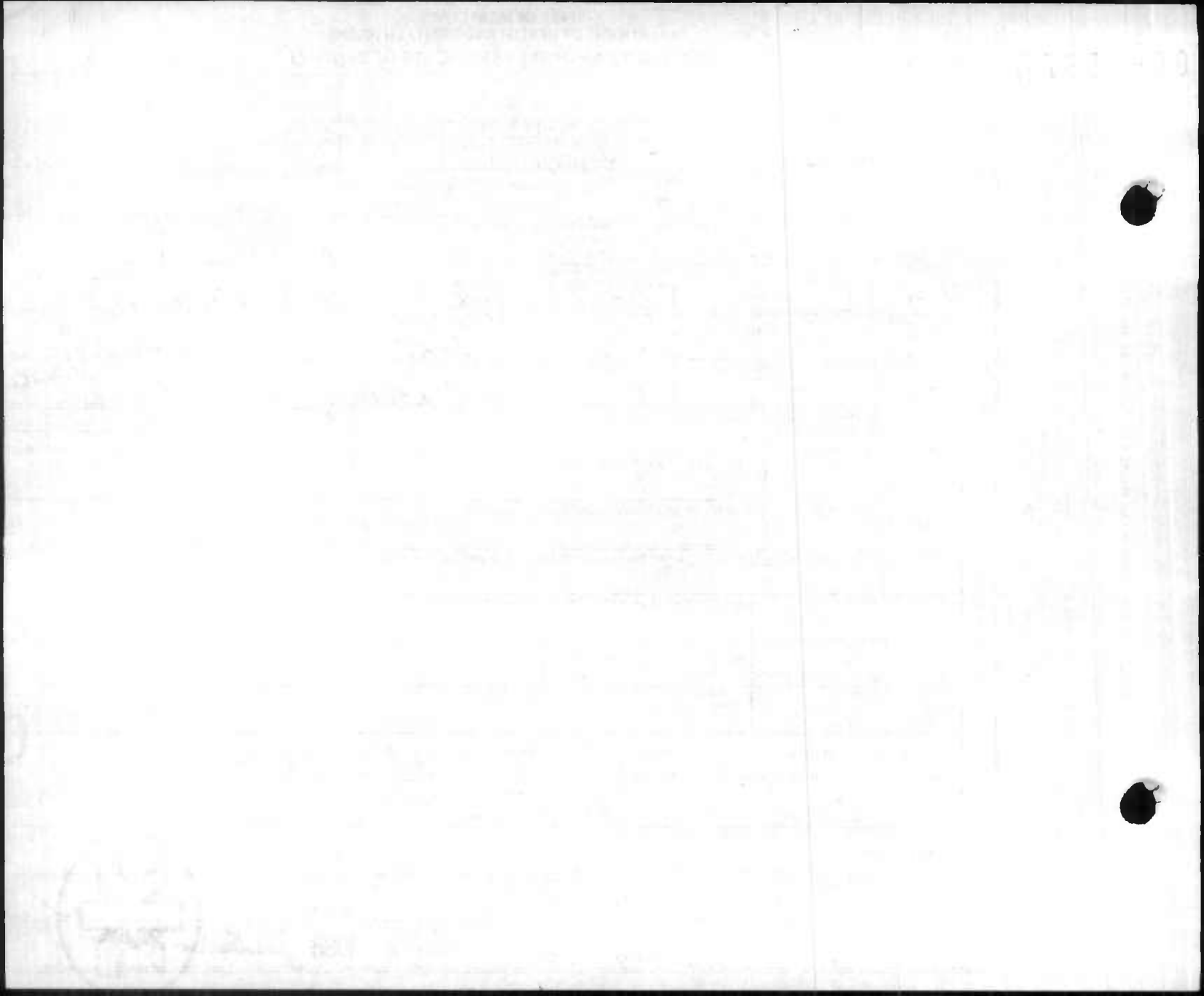
**1- FOR  
STATE  
REGISTRAR**

<b>1. DECEASED NAME</b> (TYPE OR PRINT) <b>FIRST</b> <b>MIDDLE</b> <b>LAST</b> <b>SHAWNITA CLARK</b>			<b>2a. DATE KNOWN OF DEATH</b> <input checked="" type="checkbox"/> <b>MONTH</b> <b>DAY</b> <b>YEAR</b> <b>4 30 1986</b>		<b>2b. HOUR</b> <b>M</b>
<b>3. SEX</b> <b>F.</b>	<b>4. RACE</b> <b>Negro</b>	<b>5. DATE OF BIRTH</b> MONTH <b>12</b> DAY <b>17</b> YEAR <b>85</b>	<b>6. AGE (IN YEARS)</b> LAST BIRTHDAY <b>4 MONTHS</b>	<b>IF UNDER 1 YR.</b> MONTHS <b>4</b> DAYS <b>17</b> HOURS <b>17</b> MIN. <b>17</b>	<b>IF UNDER 24 HRS.</b>
<b>7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)</b> <b>M.D.</b>		<b>7b. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>8. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10. CITY OR TOWN OF DEATH</b> <b>Baltimore</b>		<b>11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION</b> (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b>		<b>12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)</b> <b>None</b>	
<b>13a. STATE</b> <b>md</b>		<b>13b. COUNTY</b> <b>BALTO</b>		<b>13c. CITY OR TOWN</b> <b>BALTO</b>	
<b>14. FATHER'S NAME</b> FIRST <b>RUFUS</b> MIDDLE <b>CLARK</b> LAST <b>CLARK</b>		<b>15. MOTHER'S MAIDEN NAME</b> FIRST <b>LORE</b> MIDDLE <b>LAWSON</b> LAST <b>LAWSON</b>			
<b>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (YES, NO, OR UNKNOWN) <b>NO</b>		<b>16b. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>LORE LAWSON</b>	
<b>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</b> PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Sudden Infant Death Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1</b>					
<b>19a. DATE OF OPERATION</b>		<b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</b>			<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b>		<b>21b. TIME OF INJURY</b> HOUR A.M. MONTH DAY YEAR P.M. 19		<b>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)</b>	
<b>21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK</b>		<b>21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)</b>		<b>21f. LOCATION</b> CITY OR TOWN COUNTY STATE	
<b>22a. I certify that I took charge of the remains described above, held on</b> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <i>Dennis F. Smyth</i>		<b>TITLE (SPECIFY)</b> <b>M.D. Assistant</b>		<b>DATE SIGNED</b> <b>5-1-86</b>	
<b>EXAMINER'S NAME (TYPE OR PRINT)</b> <b>Dennis F. Smyth</b>		<b>ADDRESS</b> <b>111 Penn St., Balto., MD 21201</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>BURIAL</b>		<b>23b. DATE</b> <b>5/5/86</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>BALTO. Cem.</b>	
<b>24. FUNERAL DIRECTOR</b> NAME <b>Betts Funeral Home</b> ADDRESS <b>1129 N Caroline ST</b>		<b>25a. DATE REC'D. BY REGISTRAR</b> <b>MAY 2 1986</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP



00-03793

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 5 5 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDDIE B CLARKE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 11 86</b>		2b. HOUR <b>6:57p M</b>
3. SEX <b>m</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 26 20</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>
7a. BIRTHPLACE (STATE OR FOREIGN) <b>GA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LOCH RAVEN VETERAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>JANITORIAL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLEANING</b>

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>822 EAST NORTH AVENUE 21202</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>STOKES CLARKE SR.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CORA MCCLAIN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>252-26-9122</b>	17. INFORMANT ADDRESS <b>BERNICE CLARKE 2017 WESTWOOD AVE.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC ADENOCARCINOMA OF COLON</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>April 8</u> , 19 <u>86</u> , to <u>April 11</u> , 19 <u>86</u> that (1) (we) lost saw the deceased alive on <u>April 11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.					
22b. SIGNATURE <i>Allen L. Dollar</i>		DEGREE <b>Allen L. Dollar, M.D.</b>		22c. DATE SIGNED <b>4/11/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>4-17-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GARRISON FOREST</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>OWINGS MILL MD.</b>
24. FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H INC. 1101</b>		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>APR 16 1986 John Davidson-Rendall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Please remove carbon copies. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at

03-035423

03-035423



00-05091

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 5 5 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED MIDDLE R. NMN LAST CLAY			2a. DATE OF DEATH MONTH DAY YEAR 4 24 86		2b. HOUR 6:31 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7 14 22		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dissem. Line		12b. KIND OF BUSINESS OR INDUSTRY Locke Insul.
13a. STATE MD		13b. COUNTY ---		13c. CITY OR TOWN Baltimore City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Henry MIDDLE RAEHNER LAST		15. MOTHER'S MAIDEN NAME FIRST Mamie MIDDLE BEEZ LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 218183620		17. INFORMANT Crawford M. Clay, Jr. 3937 Chaffey Rd. XXXX Randallstown 21133				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF } (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours ?						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Cerebrovascular Accident						
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that this hospital attended the deceased from 4-23, 19 86 to 4-24, 19 86, that (we) lost saw the deceased (circle one) above (1) (we) did not view the body after death.						
22b. SIGNATURE Mitchell J. Leboy		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-24-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mitchell J. Leboy M.D.		22e. ADDRESS 3001 S. Hanover St Balto MD 21230				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-28-86		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. A.A. MD
24. FUNERAL DIRECTOR NAME McCully Funeral Homes		237 E. Patapsco Ave. BALTO., MD 21225		25a. DATE REC'D. BY REGISTRAR APR 29 1986		25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610557

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
Marie Clayton		April 12, 1986		12:48 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Black	MONTH DAY YEAR	78 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U.S.A.		BALTIMORE CITY, MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	715 EAST PRESTON STREET		N/A		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Baltimore	715 E. Preston St. 21202	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Johnson Elam		Linda Pettus			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS		
NO		212-40-1079	Mary Elam 715 East Preston Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>ventricular arrhythmia</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) <u>congestive heart failure</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
<u>colon cancer</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>82</u> to <u>April</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>MA Dobyns</u>		MD		<u>4/14/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<u>MA Dobyns</u>		<u>2822 Hollins Ferry Rd Balto.</u>			
23b. BURIAL, CREMATION, REMOVAL		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		4/16/86	Eastview Memorial Pk.	Baltimore, Md	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
March Funeral Homes 1101 East North Avenue		APR 15 1986		<u>Jana Davidson</u>	

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00-04398

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on a certificate issued in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10558  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM K. CLEEK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 20 86</b>		2b. HOUR <b>9:12 A.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 17 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Loch Raven VA</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Self Employed Groceries</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Cleek</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Payton Adams</b>				13e. STREET ADDRESS / ZIP CODE <b>3013 Orlando Ave. 21234</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII 255-28-5335</b>		17. INFORMANT ADDRESS <b>Mary Cleek, Same as 13e</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>MI</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Adenocarcinoma Sepsis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 4/7 19 86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4/7 86 to 4/20 86</b>		21g. (we) last saw the deceased alive on <b>4/20 86</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.	
22a. SIGNATURE <b>K Hesley MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/20/86</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K Hesley</b>		22d. ADDRESS <b>Loch Raven VA</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-23-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Carroll Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 22 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-04534

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10559  
REG. NO.

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		FIRST Carl	MIDDLE E	LAST Clemons	2a DATE OF DEATH MONTH DAY YEAR		2b HOUR a M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 7 28 36		6 AGE (IN YEARS LAST BIRTHDAY) 49		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital, 900 Caton Ave				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Interior Decorator-Decorating		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 221 S Woodyear St. 21223		
14 FATHER'S NAME FIRST MIDDLE LAST Herman Lee Clemons		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice E. Dawley		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 215309355		17 INFORMANT ADDRESS Beatrice D. Malat, 159 Wileys Lane, 21122		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <u>4/23</u> , 19 <u>86</u> , to <u>4/23</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>4/23</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE M. Nasir		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 4/23/86				
22d PHYSICIAN'S NAME (TYPE OR PRINT) POKHAR NASIR				22e ADDRESS ST AGNES HOSPITAL 900 CATON AVENUE 21228 BAL MD						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4/25/86		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A.A. Maryland				
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc., 4107 Wilkens Ave.				21229		25a DATE REGD BY REGISTRAR APR 24 1986		25b REGISTRAR'S SIGNATURE John Gordon		

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10560  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WINIFRED CORB			2a. DATE OF DEATH MONTH DAY YEAR 04-04-86			2b. HOUR 3:50 PM	
3. SEX F		4. RACE N		5. DATE OF BIRTH MONTH DAY YEAR 08 30 03		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT CITY MD	
10. CITY OR TOWN OF DEATH BALT		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF BALT				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							

13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4703 POST ROAD 21215	
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14. FATHER'S NAME FIRST MIDDLE LAST Troy Floyd			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecile Floyd		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 246-14-4824		17. INFORMANT ADDRESS Evangeline Faulkner - 4703 Post Rd 21215	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from APRIL 1 19 86 to APRIL 4 19 86, that (we) last saw the deceased alive on APRIL 4 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Robert De Marco, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-4-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT DE MARCO, MD		22e. ADDRESS SINAI HOSPITAL OF BALT 21215			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/7/86		23c. NAME OF CEMETERY OR CREMATORY AP. BUKUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALT Co. md.	
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24. FUNERAL DIRECTOR NAME Nancy M. Wallace		ADDRESS 3405 W. Franklin St		25a. DATE REC'D. BY REGISTRAR APR 09 1986		25b. REGISTRAR'S SIGNATURE John Davidson	
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MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on once

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed in the envelope and returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be indicated on page 3.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 3610561					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHRYN L COCHRAN					2a DATE OF DEATH MONTH DAY YEAR April 1 1986			2b HOUR 5:15 AM		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 3-2-1914		6 AGE (IN YEARS LAST BIRTHDAY) YRS 72		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.-		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.				
10 CITY OR TOWN OF DEATH BALTIMORE CITY		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PayRoll Dept.		12b KIND OF BUSINESS OR INDUSTRY Locke Insulator		
13a STATE Md.					13b COUNTY		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Luckhardt					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Renner					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 215-10-3828		17 INFORMANT ADDRESS Marie H. Mintiens - 2807 Bauernwood Ave. 21234						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from Feb 20 1986 to April 1 1986, that (I) (we) last saw the deceased alive on April 1 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE John P. Serlemittos				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 4/1/86				
22d PHYSICIAN'S NAME (TYPE OR PRINT) John P. Serlemittos				22e ADDRESS Union Memorial Hospital - Baltimore						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4-3-86		23c NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Balto. Md.		23d LOCATION CITY OR TOWN COUNTY STATE				
24 FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE APR 02 1986 John Davidson Renshaw				

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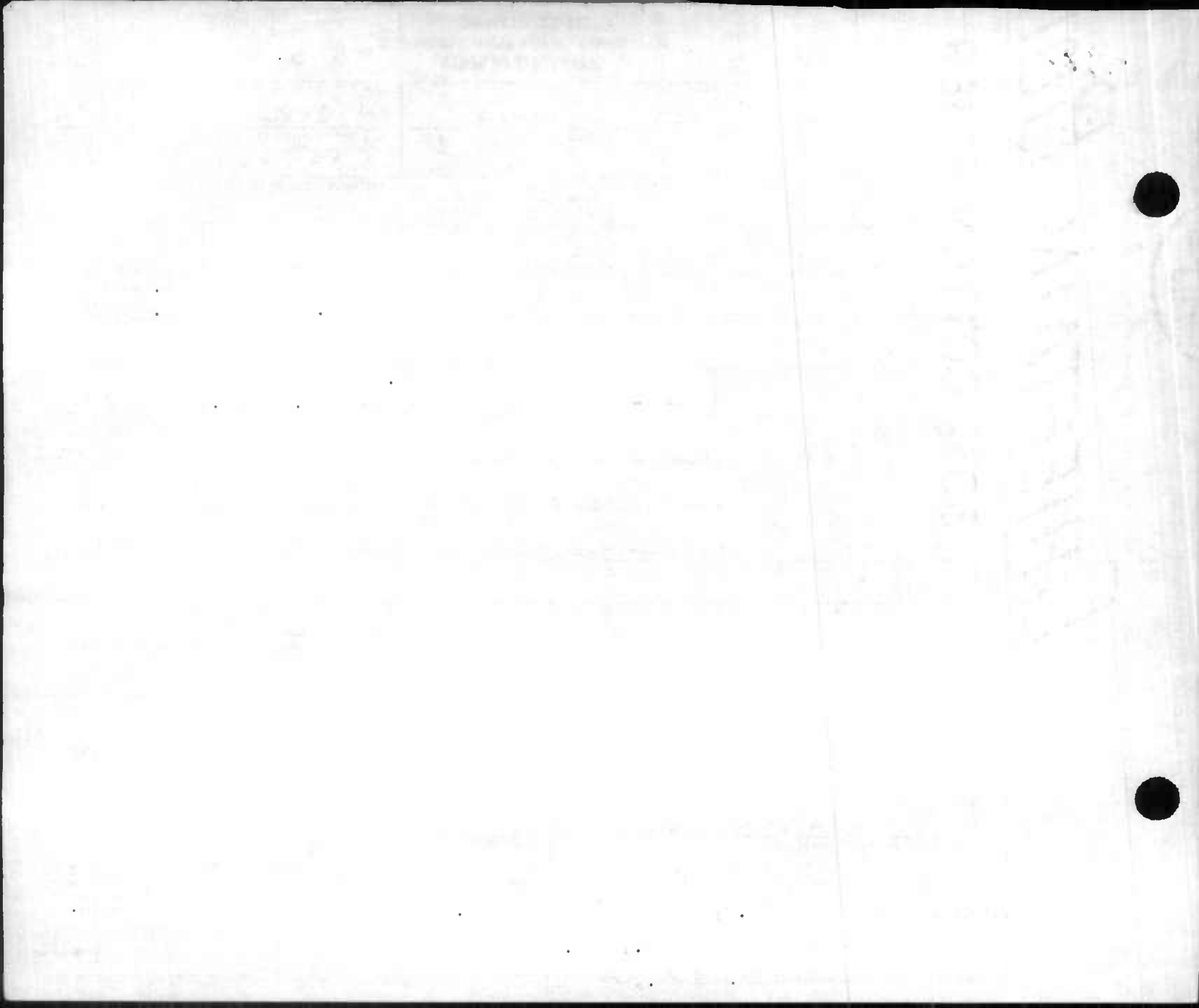
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10562  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTHER TINA COHEN		2a. DATE OF DEATH MONTH DAY YEAR 4-2-86		2b. HOUR 10 <sup>45</sup> AM	
3. SEX FEMALE		4. RACE WHITE W		5. DATE OF BIRTH MONTH DAY YEAR 01-20-01	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST PAUL GRAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 010-05-8439D		17. INFORMANT MRS. CHARLOTTE TOBIN		18. ADDRESS 6719 GREENSPRING AVE. BALTO., MD 21209	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) known conduction defect DUE TO, OR AS A CONSEQUENCE OF (c) known atherosclerotic cardiovascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 177 MINUTE 70s 70s					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1a N/A					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT HOME <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) this hospital attended the deceased from 11-1, 19 83, to 4-2, 19 86, that (2) I saw the deceased alive on 4-2, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE AJ Lewin		DEGREE MD		22c. DATE SIGNED 4-2-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AJ Lewin		22e. ADDRESS 2434 W BELVEDERE AVE BALTO MD 21215			
23a. BURIAL, CREMATION, REMOVAL REMOVAL/BURIAL		23b. DATE APR. 4, 1986		23c. NAME OF CEMETERY OR CREMATORY BNAI BRITH CONG.	
				23d. LOCATION PEABODY COUNTY MASS.	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR APR 04 1986	
				25b. REGISTRAR'S SIGNATURE Jone Davidson-Randall	



00-047541-1

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10563  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEE M. COHEN			2a. DATE OF DEATH MONTH DAY YEAR APRIL 20, 1986		2b. HOUR 6:05 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCT. 23, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2816 W. STRATHMORE AVE. (21209)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY LAW
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST SIMON COHEN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH KOLKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-10-4658		17. INFORMANT ADDRESS MRS. SUSAN LEE SCHWARTZ 4717 BYRON RD. (21208)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Melanotic carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cervical cancer</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/8</i> , 19 <i>86</i> , to <i>4/21</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) (not) saw the body after death.					
22b. SIGNATURE <i>Peter Oroszlan</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Oroszlan		22e. ADDRESS 1777 Reisterstown Rd. Baltimore, Md. (21208)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/22/86	23c. NAME OF CEMETERY OR CREMATORY Beth Tfiloh Cong.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto, Md.	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO, MD. (21215)		25a. DATE REC'D. BY REGISTRAR APR 25 1986		25b. REGISTRAR'S SIGNATURE <i>Julia...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100% COTTON YARN

00-039116

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10564

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ronald Coleman			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 4-10 19 86		2b. HOUR M 2:52 a.m.
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 9 8 60	6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4-10 19 86	7d. HOUR M 2:52 a.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mixer operator	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Harford	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Coleman Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Erlaise Jenkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-TP-3843		17. INFORMANT ADDRESS William Coleman same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple & Thermal Injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 4-9 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject in explosion	
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) work site		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1354 Old Post Rd., Harve De Grace, Harford Co., Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER DATE SIGNED 4-10-86	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/10/86		23c. NAME OF CEMETERY OR CREMATORY St. James United	
24. FUNERAL DIRECTOR NAME Arnold W. Beard		ADDRESS Harve De Grace, Md.		25a. DATE REC'D. BY REGISTRAR APR 17 1986	
				25b. REGISTRAR'S SIGNATURE John D. ...	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

11890-2



00-04843

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10565

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Constance J. Collins			2a. DATE OF DEATH MONTH DAY YEAR 4 25 86			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 12 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wyoming		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18 South Wolfe Street 21231				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank H. Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Gasman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 235-92-5226		17. INFORMANT ADDRESS William Gunther, Jr. 18 S. Wolfe St. 21231			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). DUE TO, OR AS A CONSEQUENCE OF: (c).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
Hepatic Coma		Workosis of the Liver	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERWAY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, YARD, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 3/5/86 to 3/5/86 and that in my (our) opinion death occurred on the date and hour and from the causes stated		22b. DATE SIGNED 4/25/86		22c. SIGNATURE DEGREE Attending Physician <input checked="" type="checkbox"/> Medical Director <input type="checkbox"/> Staff Physician <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD M. PACHUTA		22e. ADDRESS 2903 N. CHARLES ST BALTIMORE MD 21201					

23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 4/28/86		23c. NAME OF CEMETERY OR CREMATORY St. Lukes Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fine Creek Mills Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. 21211				25a. DATE REC'D. BY REGISTRAR APR 25 1986			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-03499

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

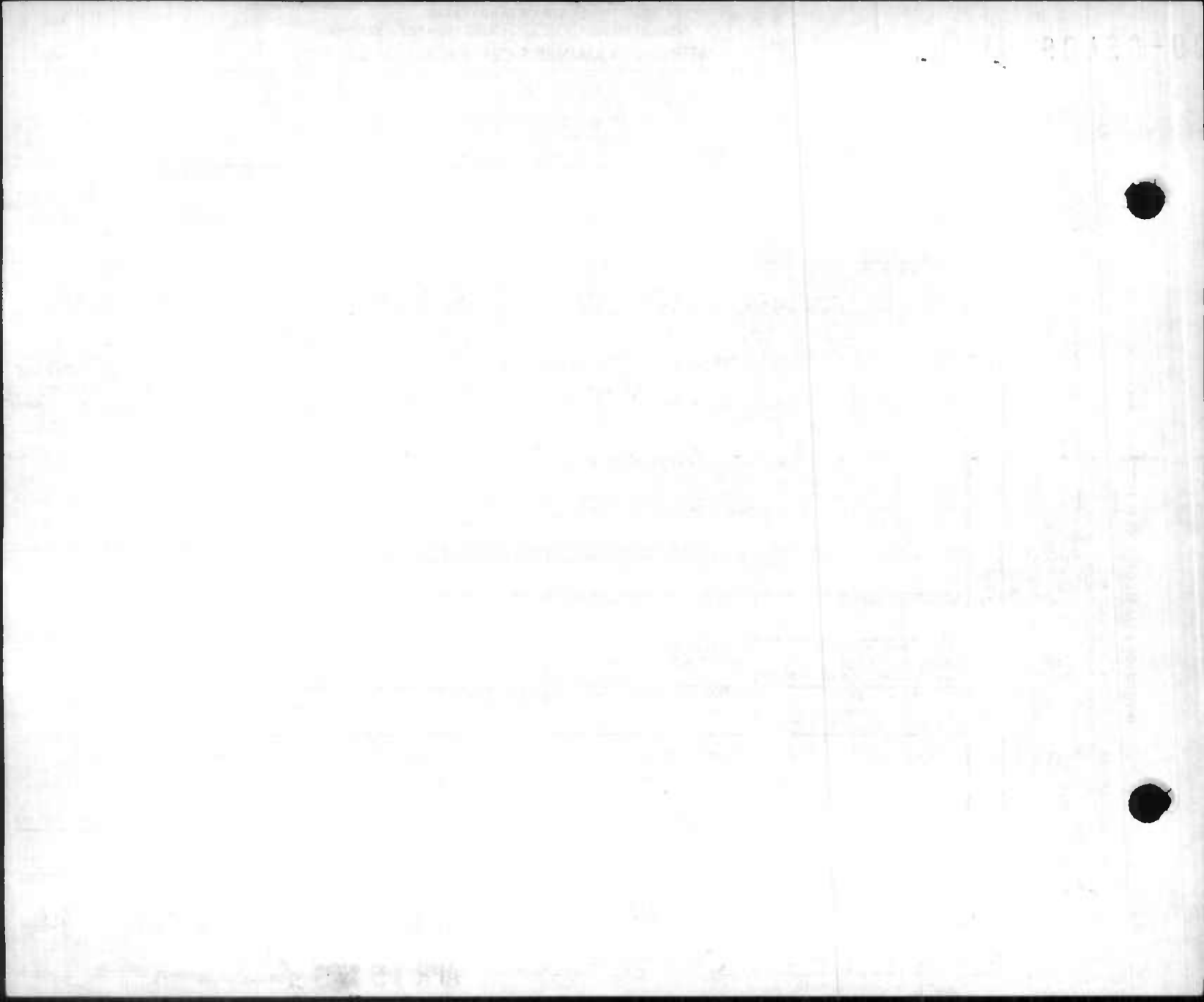
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0566			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Natasha Joi Collins										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 3/ 21/ 19 86		2b. HOUR M 3:00 P M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 03 07 86		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 14		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3/ 21/ 19 86		2d. HOUR P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD				13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3836 Old Federal Hill Road 21205			
14. FATHER'S NAME FIRST MIDDLE LAST John Edward Collins						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Georgette Tittle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. None		17. INFORMANT Mother		ADDRESS Same Hill Rd Jarrettsville MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE _____						TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.						ADDRESS 111 Penn St.			DATE SIGNED 3/22/86				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 03/26/86		23c. NAME OF CEMETERY OR CREMATORY MD Veteran's Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Anne Arundel MD			
24. FUNERAL DIRECTOR NAME George W. Tittle						ADDRESS Jarrettsville, MD			25a. DATE REC'D. BY REGISTRAR APR 15 1986				
						25b. REGISTRAR'S SIGNATURE							

07/84  
25M

BP 110

DHMM - 17  
(VR A15 ME (15))



[illegible]

03/10/12  
CORRIG: 215 C

0 SST 04 70 r

03/10/12

00-03424

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10568  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES JOSEPH CONLON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>04 11 86</b>		2b. HOUR A <b>1:10</b> M		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 28 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>72</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Patrick Conlon</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Jane Warren</b>		13e. STREET ADDRESS / ZIP CODE <b>2137 Parksley Avenue 21230</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-07-7228</b>		17. INFORMANT <b>Beverly E. Keagle</b>		17. ADDRESS <b>3128 Ryerson Circle 21227</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Prolonged &amp; sustained ventricular arrhythmias</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-11</b> , 19 <b>86</b> , to <b>4-11</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4-11</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Jose F. Fernandez, MD</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/11/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jose F. Fernandez, MD</b>		22e. ADDRESS <b>St. Agnes Hospital Baltimore, Md. 21229</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/14/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>		ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE FILED BY REGISTRAR <b>APR 14 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP

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00-02978

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 100569

1- FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2b. DATE KNOWN OF DEATH		ESTIMATED MONTH DAY YEAR		2c. HOUR	
		SARAH M. CONYERS				XX		4 6 19 86		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Female		White		Aug. 31, 1940		45 YRS.		MONTHS DAYS HOURS MIN		2d. DATE PRONOUNCED DEAD	
										4 6 19 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		2d. HOUR	
North Carolina		USA		WIDOWED		DIVORCED		Baltimore City		435 A M	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Union Memorial Hospital		Machine Service		Vending					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1501 Gorsuch Avenue 21218			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Samuel Hawkins, Sr.		Mae Bea Price									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		216-42-2577		Mr. Samuel Hawkins, Jr.		934 Northhill Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		minutes	
				Acute Pulmonary Arterial Thrombo-embolism							
				(b)		DUE TO, OR AS A CONSEQUENCE OF					
				(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				Cerebrovascular Disease (stroke-2 weeks ago)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from:		Neurological causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. I certify that I took charge of the remains described above, held on death resulted from:		Neurological causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		4-6-86					
EXAMINER'S NAME (TYPE OR PRINT)		John E. Smialek, MD.		ADDRESS		111 Penn St., Balt., MD		21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		4/9/86		Arbutus Memorial		Baltimore County		Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Leonard J. Ruck, Inc.		5305 Harford Road 21214		APR 09 1986		John Davidson					

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

1-0500

Jan. 21, 1960

Mr. J. L. ...

Dear Sir:

Enclosed for you are two copies of the report of the ...

... of the ...

... of the ...

... of the ...

Sincerely,

...

Very truly yours,  
...



*[Handwritten signature]*

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00-03427

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10570

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HELEN C. COOK</b>			2a DATE OF DEATH MONTH DAY YEAR <b>4 11 86</b>		2b HOUR <b>2:15 P.M.</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>4 25 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS	
7a BIRTHPLACE (COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Packer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Shirt Mfg.</b>

13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>2049 Grinnalds Avenue, 21230</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Henry Bollman</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude Block</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b SOCIAL SECURITY NO. <b>085-07-4027</b>		17 INFORMANT ADDRESS <b>Jessie M. Ashton, 7913 James Ave., 21043</b>		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) ASHD + Hypertension

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHminutesyears

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) <u>(the hospital)</u> attended the deceased from <u>5-13</u> 19 <u>85</u> , to <u>75</u> 19 <u>85</u> , that (I) <u>did</u> last saw the deceased alive on <u>5-13</u> 19 <u>85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.			
22b SIGNATURE <u>Dr. Turkman</u> MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <b>4-11-86</b>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Turkman</b>		22e ADDRESS <b>2601 Washington Blvd.</b>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>	23b DATE <b>4/15/86</b>	23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Mausoleum</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>
24 FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>		ADDRESS <b>21229 4107 Wilkens Ave.</b>	25a DATE REC'D. BY REGISTRAR <b>APR 14 1986</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10571

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ALFRED ANDREW COOLEY</b>			2a DATE OF DEATH MONTH DAY YEAR <b>4 6 86</b>		2b HOUR <b>4:05 PM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>May 16, 1903</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>James Cooley</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		12b USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffeur</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO <b>216-01-1973</b>		17. INFORMANT <b>Gregory A. Cooley</b> ADDRESS <b>1609 Feldbrook Rd. Towson, Md. 21204</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Yr/hr</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b>					<b>SEVERAL Yrs</b>
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/6/86</b> , 19 <b>86</b> , to <b>4/6/86</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>4/6/86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John Thomas Evecius MD</b>				22c. DATE SIGNED <b>4/6/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN THOMAS EVECIOUS</b>				22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Cremation</b>		23b. DATE <b>April 7, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>	
24 FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21214</b>		23d. LOCATION <b>Baltimore City, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>PR 10 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendall</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST JACK MIDDLE F. LAST COOPER  
2a. DATE OF DEATH MONTH 4 DAY 7 YEAR 1986 2b. HOUR 6:45 M  
3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH 8 DAY 7 YEAR 11 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.  
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.  
10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN CITY OR TOWN, GIVE STREET ADDRESS) Sinai Hospital 12a. USUAL OCCUPATION Retired Office Manager 12b. KIND OF BUSINESS OR WORK FOR MOST OF WORKING LIFE Macomas Fuel Oil Co.  
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY 13b. COUNTY 13c. ZIP AND TOWN 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 14. FATHER'S NAME FIRST Andrew MIDDLE LAST Cooper 15. MOTHER'S MAIDEN NAME FIRST Naomi MIDDLE Cline LAST  
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No 16b. SOCIAL SECURITY NO. 212-12-0964 17. INFORMANT ADDRESS Merle D. Cooper Same as # 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Pulmonary Embolism  
DUE TO, OR AS A CONSEQUENCE OF (b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF (c) \_\_\_\_\_  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Cordiac Ischemia

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐  
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  
21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  
22a. I certify that (I) (this hospital) attended the deceased from 4/7/86, 19 86, to 4/7/86, 19 86, that (I) (we) last saw the deceased alive on 4/7/86, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  
22b. SIGNATURE DEGREE 22c. DATE SIGNED 4/7/86  
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS SINAI HOSP. OF BALTO MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 4/10/86 23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville MD.  
24. FUNERAL DIRECTOR 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
Terry M. & Russell C. Witzke, Funeral Homes P.A.  
1630 Edmondson Avenue, Catonsville, MD. 21228  
APR 10 1986

12967-



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		86 10573				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Willie G. CORBETT								April 4, 1986		6:00P <sub>M</sub>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Black		MONTH DAY YEAR 3 28 09		77		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
N.C.		USA				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Maryland General Hospital				Retired		Davidson			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.				Balto.				1932 W. Lexington St. 21223			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Listen Corbett		Unkn									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		217-07-3164 A		Willie Mae Corbett		1932 W. Lexington St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic cardiovascular disease</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) this hospital attended the deceased from <u>March 13</u> , 19 <u>86</u> , to <u>April 4</u> , 19 <u>86</u> that <u>X</u> (we) lost <u>X</u> (we) did <u>X</u> (we) did not view the body after death.											
22b. SIGNATURE <u>[Signature]</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/3/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jonathan D. Kushner</u>						22e. ADDRESS <u>c/o Maryland General Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		4/8/86		Arbutus Mem. Pk.		Arbutus, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm C March F/H West 4300 Wabash Avenue						APR 08 1986		<u>[Signature]</u>			

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

10574

1 DECEASED NAME (TYPE OR PRINT) <b>Alvin Core</b>			2a DATE OF DEATH MONTH DAY YEAR <b>April 5, 1986</b>		2b HOUR <b>4:55P.M.</b>	
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>05-06-1918</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		MD		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b KIND OF BUSINESS OR INDUSTRY		13a STATE <b>MARYLAND</b>		13b COUNTY <b>BALTIMORE</b>		
13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>501 DOLPHIN STREET 21217</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>JAMES CORE</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOSEPHINE JACKSON</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
16b SOCIAL SECURITY NO. <b>218-07-2835A</b>		17 INFORMANT <b>VASHTIA WOODS</b>		ADDRESS <b>501 DOLPHIN STREET</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Dysrhythmia (Ventricular Tachycardia And Fibrillation)</b> DUE TO, OR AS A CONSEQUENCE OF <b>Complete Atrioventricular Block</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Hypotension, Chronic Alcohol Abuse And Hypertension (by History)</b>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (X) (this hospital) attended the deceased from <b>April 4, 1986</b> to <b>April 5, 1986</b> , that (we) last saw the deceased alive on <b>April 5, 1986</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.		22b SIGNATURE <b>Thomas Ganey</b>		
22c DATE SIGNED <b>4/5/86</b>		22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas Ganey, M.D.</b>		22e ADDRESS <b>c/o Maryland General Hospital</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>4-10-86</b>		23c NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN CEMETERY</b>		
23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>		24 FUNERAL DIRECTOR NAME ADDRESS <b>BROWN/THOMPSON F.H. 1913 W. BALTO. ST.</b>		25a DATE REC'D. BY REGISTRAR <b>APR 15 1986</b>		
25b REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CONSTANTINIA CORNIAS					2a. DATE OF DEATH MONTH DAY YEAR April 4, 1986			2b. HOUR 7:10A <sup>M</sup>	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 26 03		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 82		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 815 Tolna Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 815 Tolna Street 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Valis					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anthipi Moniodis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-42-7378A		17. INFORMANT ADDRESS William Cornias, 803 Tolna Street Baltimore, Md. 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>xxx</del> hospital) attended the deceased from 19 84 to 3-27 19 86, that (I) <del>xxx</del> last saw the deceased alive on 3-27 19 86, and that in (my) <del>xxx</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>xxx</del> (did not view the body after death).									
22b. SIGNATURE <i>Melito M. Torres</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-4-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melito M. Torres, M.D.				22e. ADDRESS 441 S. Ellwood Ave. Balto. Md. 21224					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-7-86		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.			
24. FUNERAL DIRECTOR Ann M. Matthews, Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224						25a. DATE REC'D. BY REGISTRAR APR 09 1986		25b. REGISTRAR'S SIGNATURE <i>J. Davidson</i>	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified for notification of the medical examiner.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
FIRST MIDDLE LAST		4 5 86		5:26 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Black		12 31 1907		78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		U.S.A.				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR WORK, BUSINESS OR INDUSTRY)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Union Memorial		Retired			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		A.A.		Severna Park		13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
James		Rachel		NO		Edna Jennings-6654 Kober 75 Ct.	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		19. DATE OF OPERATION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Edna Jennings		Ventricular Fibrillation		Bacteroides		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		DUE TO, OR AS A CONSEQUENCE OF					
		DUE TO, OR AS A CONSEQUENCE OF					
		DUE TO, OR AS A CONSEQUENCE OF					
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
		Bacteroides Sepsis, Wound Abscess, Necrotizing Fasciitis, Atelectasis of Esophagus					
21a. TIME OF INJURY		21b. HOW INJURY OCCURRED		21c. LOCATION		21d. DATE SIGNED	
HOUR A.M. MONTH DAY YEAR		[ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2]		CITY OR TOWN COUNTY STATE		4/5/86	
P.M.							
21e. PLACE OF INJURY		21f. DATE SIGNED		21g. DATE SIGNED		21h. DATE SIGNED	
[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		4/5/86		4/5/86		4/5/86	
22a. I certify that (I) (this hospital) attended the deceased from		22b. I certify that (I) (this hospital) attended the deceased from		22c. I certify that (I) (this hospital) attended the deceased from		22d. I certify that (I) (this hospital) attended the deceased from	
4/5/86		4/5/86		4/5/86		4/5/86	
and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated	
22e. SIGNATURE		22f. SIGNATURE		22g. SIGNATURE		22h. SIGNATURE	
Robert Vining		M.D.		M.D.		M.D.	
22i. PHYSICIAN'S NAME (TYPE OR PRINT)		22j. ADDRESS		22k. ADDRESS		22l. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		4/9/86		TOWN NECK U.M.		Severna Park, A.A. Md.	
24. FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE	
William Keese + Sons Mortuary - Anna, Md.		APR 10 1986		William Keese + Sons Mortuary - Anna, Md.		William Keese + Sons Mortuary - Anna, Md.	

2013 COLLEGE

CHIEF IN CHARGE

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86-10577  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELIZABETH L. COTTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-2-86</b>		2b. HOUR <b>10:45 PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10-12-96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOODSAMARITAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3407 White Ave. 21214</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George O. Nippard</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elosia Meise</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-48-6724</b>		17. INFORMANT ADDRESS <b>Ethel Bova 123 Madison Ave. 21030</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CHRONIC OBSTRUCTIVE PULMONARY**

DUE TO, OR AS A CONSEQUENCE OF

**DISEASE**Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-28-1986</b> to <b>4-2-1986</b> , that (I) (we) lost saw the deceased alive on <b>4-2-1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Lokenwarao Edaw</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>4.2.86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LOKE SWARAO, EDRA</b>		22e. ADDRESS <b>60 GOOD SAMARITAN HOSPITAL</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4-5-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 04 1986</b> REGISTRAR'S SIGNATURE <i>John Davidson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-03735

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of page 3.

Item 13E-5-6-86  
For Perphone A.L.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 86 10578

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruby Cousin		2a. DATE OF DEATH MONTH DAY YEAR 4 14 86		2b. HOUR 6:50 P.M.	
3. SEX Fem	4. RACE Col	5. DATE OF BIRTH MONTH DAY YEAR 8 30 09		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital Baltimore	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Md.		12b. COUNTY Balto		12c. CITY OR TOWN Balto	
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 3404 Dolefield Ave. 21215		13c. STREET ADDRESS / ZIP CODE 3404 Dolefield Ave. 21215	
14. FATHER'S NAME FIRST MIDDLE LAST Charlie Shaw		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Turner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 217-12-3928		17. INFORMANT Rab. L. Cousin		18. ADDRESS 3404 Dolefield Ave. 21215	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ctf / Pulmonary Edema. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Possible MI					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/26, 1986, to 4/14, 1986, that (I) (we) last saw the deceased alive on 4/14, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J.M. Bestler		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.M. Bestler		22e. ADDRESS Provident Hospital Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (COPY)		23b. DATE 4-21-86		23c. NAME OF CEMETERY OR CREMATORY Garrison Vt Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co.		23e. DATE REC'D. BY REGISTRAR APR 16 1986		23f. REGISTRAR'S SIGNATURE John H. [Signature]	
24. FUNERAL DIRECTOR NAME ADDRESS Charles A. Powell - 1206 W. North Ave					



00-05290

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

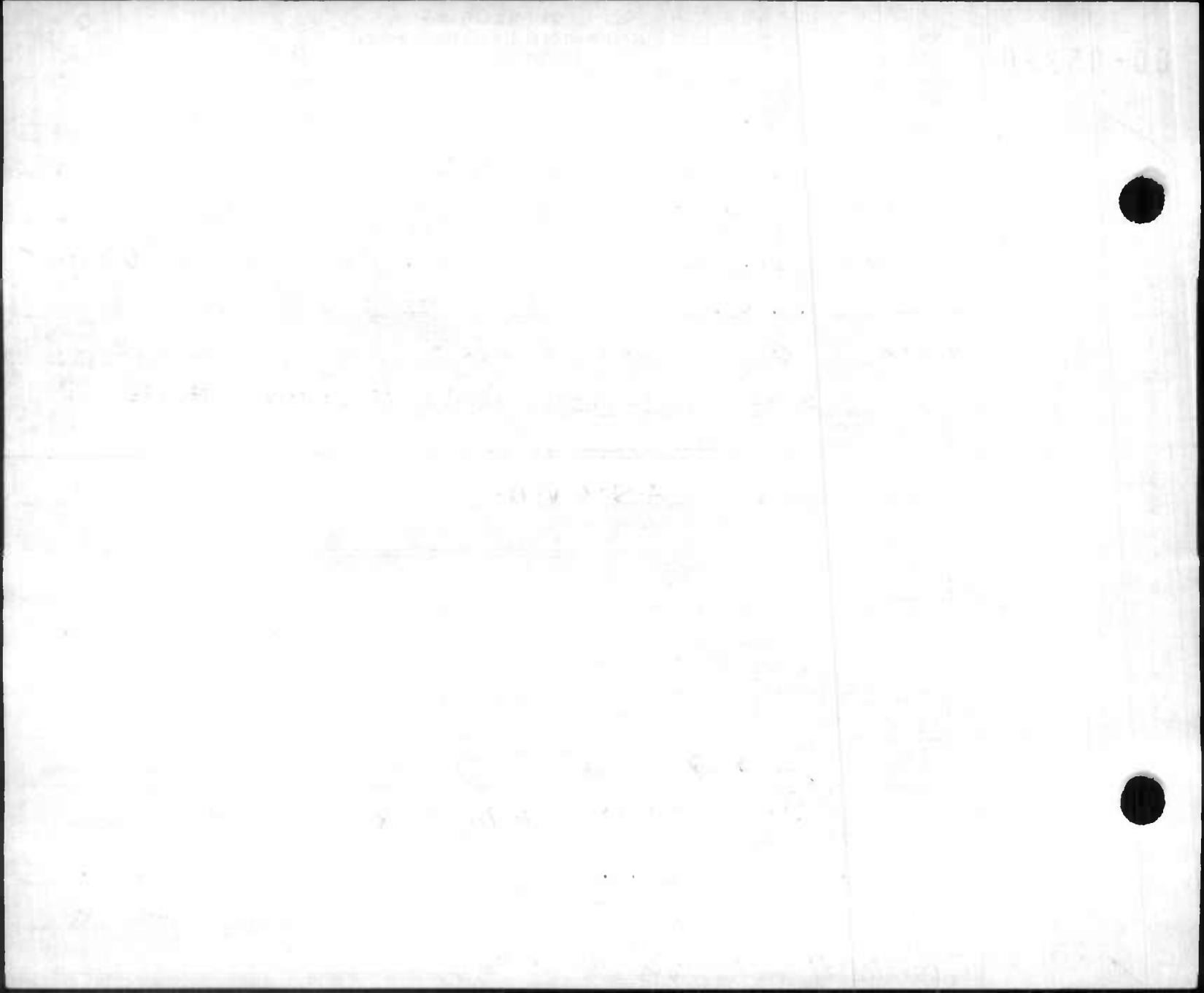
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified that the

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 5 7 9  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>IRVIN F. COWEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 27, 1986</b>		2b. HOUR M <b>AM</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASION</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5-17-1930</b>	6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>55</b>		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLAIMS EXAMINER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>A.A. CO.</b>	13c. CITY OR TOWN <b>1452 MARYLAND AVENUE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William G. Cowen SR</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Ada Lyshe</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>51-55 215-28-3548</b>		17. INFORMANT ADDRESS <b>DORIS H. Cowen #13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>8-31-85</b> , 19____, to <b>PRESENT</b> , 19 <b>86</b> , that (I) <del>XXXX</del> spw the deceased alive <b>4/27/86</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE <b>K. Dharmasena</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-28-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. DHARMASENA, M.D.</b>		22e. ADDRESS <b>#8-16th AVENUE - BALTIMORE, MD. 21225</b>			
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>BURIAL</b>		23b. DATE <b>5-1-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY U.M.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodwardville AA. MD</b>		24. FUNERAL DIRECTOR NAME <b>T. A. Hurdasty</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 1 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>Annas md. 21401</b>					

BP



00-05259

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10580

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
John Albert Cowman						4 23 19 86						M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Male		White		June 5 1917		68 YRS.		MONTHS DAYS		HOURS MIN		4 24 19 86		12:45 A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.				U.S.A.								Baltimore City MD					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore				3230 Belair Rd.				Salesman				Pie Co.					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3230 Belair Rd. 21213							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
Herbert Cowman						Mary unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
Yes						Peacetime		212-01-4963		Mary Hall (dghtr) 2030 Susquehanna Hall Rd., Whiteford Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART 1 DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) _____																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
<u>Chronic obstructive pulmonary disease</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
<i>Dennis F. Smyth</i>				M.D. Assistant MEDICAL EXAMINER				4-24-86									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Dennis F. Smyth M.D.				111 Penn St., Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN		COUNTY STATE					
BURIAL				4/26/86		Moreland Mem Pk				Baltimore		Md.					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Schimunek Funeral Home, Inc.						APR 30 1986				<i>John Davidson</i>							
3331 Brehms Lane, Balto. Md. 21213																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE GENERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 0 5 8 1

1. DECEASED NAME (TYPE OR PRINT) <b>DANIEL D. COX</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 26 86</b>			2b. HOUR <b>6:20<sup>P</sup><sub>M</sub></b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 16, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER BALTIMORE MD</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Broker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Pikesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6634 Earle Drive, 21215</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel D. Cox</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Clarke</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea 562 36 2821</b>		17. INFORMANT ADDRESS <b>Allison A. Cox, 5 Rosecrance Place, 21236</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Metastatic Lung cancer to Brain And Spine</u> DUE TO, OR AS A CONSEQUENCE OF } (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>APRIL 10</u> , 19 <u>86</u> , to <u>APRIL 26</u> , 19 <u>86</u> , that (I/we) last saw the deceased alive on <u>APRIL 26</u> , 19 <u>86</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <del>not</del> view the body after death.									
22b. SIGNATURE <u>Scott Berger</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/28/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Scott Berger</u>					22e. ADDRESS <u>3900 Loch Raven Blvd. Baltimore Md 21218</u>				
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b. DATE <b>4/29/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn, Baltimore Co., Md</b>		
24. FUNERAL DIRECTOR <b>JAMES N. KOTSIS F.H., 6411 Windsor Mill Rd.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 5 1986</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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U.S. DEPARTMENT OF AGRICULTURE

THE UNIVERSITY OF CHICAGO

1/23/80      Los Alamitos Cemetery      Los Alamitos, California 90601

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610582  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Madeline V. Cox		2a. DATE OF DEATH MONTH DAY YEAR 4-21-86		2b. HOUR G:52 P.M.	
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 12 15 00		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home Maker
13a. STATE MD	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3713 4th St 21225	
14. FATHER'S NAME FIRST MIDDLE LAST George Bower		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Gregory			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-54-1852		17. INFORMANT ADDRESS Melvin Cox 3713 4th St Baltimore, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Multi system failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Status Post small and large bowel resection</u>					
19a. DATE OF OPERATION 7-24-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene of Bowel		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> 19 <u>86</u> to <u>4-21</u> 19 <u>86</u> that (I) (we) lost saw the deceased alive on <u>4-21</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Mitchell Jelen M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 4-21-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mitchell Jelen M.D.		22e. ADDRESS 7001 S. Harrower St, Balto MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/25/86		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore == Md					
24. FUNERAL DIRECTOR George J. Gonce		4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR APR 25 1986	
		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

2025 COLLECTION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10583  
REG. NO

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20a. DATE OF DEATH		MONTH		DAY		YEAR		20b. HOUR	
TARA		MICHELLE		COX				APRIL 1, 1986								01:30PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		(IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
FEMALE		WHITE		OCT. 25 1975		10		YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
TEXAS		U.S.A.				BALTIMORE CITY										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		STUDENT													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
MD.		BALTO.		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4322 PENN AVE. 21236									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
TERRY		COX		LYNN		SEWELL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		214-98-1474		LYNN PHILLIPS (MOTHER)		SAME ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
8199		Brain death		Trauma from being struck by		automobile.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 3/29/1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/29 1986 to 4/1 1986 that (b) (we) lost saw the deceased alive on 4/1/86 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)		22b. SIGNATURE Steve D. Barnes, MD		DEGREE ATTENDING PHYSICIAN		STAFF PHYSICIAN		22c. DATE SIGNED 4/1/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. CITY OR TOWN		22g. COUNTY		22h. STATE									
Steve D. Barnes		Johns Hopkins Hospital		BALTIMORE		BALTIMORE		MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
BURIAL		4/5/86		GARDENS OF FAITH		BALTIMORE		BALTIMORE		MD.							
24. FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
SCHIMUNEK FUNERAL HOME, INC. 9705 Belair Rd., Balto. Md. 21236		APR 04 1986		Steve D. Barnes													

100

550 P8 85

0-03366

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITALS AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

Theodore A. Crabtree

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO. 10584

1. DECEASED NAME (TYPE OR PRINT) <b>THEODORE CRABTREE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4/10/86</b>		2b. HOUR <b>4:40 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7/17/14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS. <b>3</b> MONTHS <b>3</b> DAYS <b>0</b> HRS. <b>0</b> MIN.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRIEDLER'S Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Enameler</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b> COUNTY <b>Baltimore</b> CITY OR TOWN <b>Essex</b>			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS <b>101 Langley Road 21221</b>
14. FATHER'S NAME FIRST <b>Arqule</b> MIDDLE <b>Crabtree</b> LAST <b>Crabtree</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Estelle</b> MIDDLE <b>Myers</b> LAST <b>Myers</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO <b>220104851</b>		17. INFORMANT ADDRESS <b>437 S. Kentucky Ave</b> <b>Donna Jean Crim Daughter Martinsburg W Va.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac x Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Obstructive lung disease - Hypoxia severe with emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cancer of colon - large intestine</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Cancer of colon - large intestine</b>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>April 4</b> 19 <b>86</b> , to <b>April 10</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>April 10</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Manuel Levin M.D.</b>		22c. DATE SIGNED <b>4/10/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MANUEL LEVIN M.D.</b>		22e. ADDRESS <b>6101 PARK AVE BALTO MD 21213</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4/12/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>
24. FUNERAL DIRECTOR <b>Brudzinski Funeral Home PA 1407 Old Eastern Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 11 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>





00-04803

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO. 10585

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEWIS S CRAPOCK			2a. DATE OF DEATH MONTH DAY YEAR 4 24 86		2b. HOUR 210 AM
3. SEX male	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 6 6 18		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) P. W. VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALT. GENERAL HOSP.		12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE MD 12b. COUNTY BALT 12c. CITY OR TOWN BALT	12a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	12a. STREET ADDRESS / ZIP CODE 3706 PENNINGTON AVE. 21226
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE CRAPOCK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HAZEL SLATE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <del>XXX</del> No		16b. SOCIAL SECURITY NO. 230-16-1559		17. INFORMANT Kenneth Kimble Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral infarction DUE TO, OR AS A CONSEQUENCE OF A.S.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-15, 1986, to 4-24, 1986, that (I) (we) last saw the deceased alive on 4-24, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael E. Collier, M.D.				22c. DATE SIGNED 4/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. COLLIER, M.D.				22e. ADDRESS 3001 S. HANOVER BALTIMORE, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-28-86	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Balto. A.A. MD	
24. FUNERAL DIRECTOR NAME McCully Funeral Homes Balto., MD 21225			25a. DATE REC'D. BY REGISTRAR APR 25 1986	25b. REGISTRAR'S SIGNATURE	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

2000-0

00-05291

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised of same.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8610586  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) RICHARD Harold CRADDOCK			2a. DATE OF DEATH MONTH DAY YEAR APRIL 28, 1986		2b. HOUR 6:52A M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR January 7, 1921		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		12b. KIND OF BUSINESS OR INDUSTRY Ship Yard
13a. STATE Maryland			13b. COUNTY --	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Craddock			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy A. White		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 241 24 4154		17. INFORMANT ADDRESS Roper, Nothe Carolina Cecil Craft, Jr. P.O. Box 25	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acidosis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 min 2 hrs 6 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Upper GI Bleed</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>4/27</u> 19 <u>86</u> to <u>4/28</u> 19 <u>86</u> , that (we) last saw the deceased alive on <u>4/28</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Edward Kasper MD</u>				22c. DATE SIGNED 4/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EDWARD KASPER</u>				22e. ADDRESS <u>Johns Hopkins Hospital</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04/30/86	23c. NAME OF CEMETERY OR CREMATORY Hill Side Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Plymouth, Washington Co., N.C.
24. FUNERAL DIRECTOR NAME Burgess-Hennessy Funeral Home			25a. DATE REC'D. BY REGISTRAR MAY 1 1986		25b. REGISTRAR'S SIGNATURE <u>Gula Davidson-Randall</u>

00-02231

100-55-750  
CHANDLER, JOSEPH  
1870-1910



2025 RELEASE UNDER E.O. 14176

00-04078

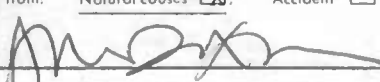

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

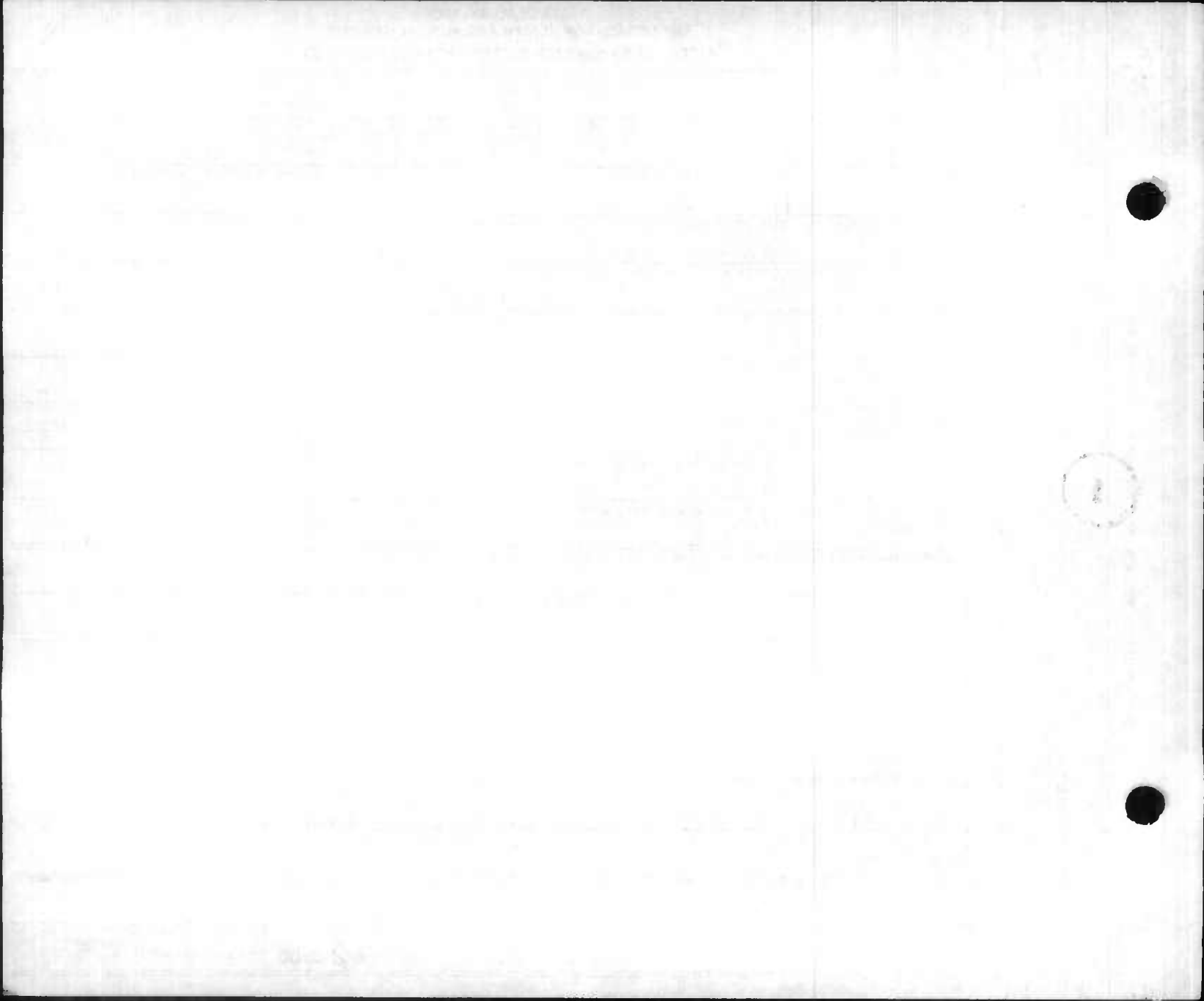
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10587	
1- FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) <b>ETHEL CRAVEN</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3 23 1986	
3 SEX <b>Female</b> 4 RACE <b>Black</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>7 14 11</b> 6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>74</b>										7b. HOUR <b>12:59 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>313 N. Calhoun St.</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>313 N. Calhoun St. 21223</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Fennell</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jesse Boone</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO. <b>215-22-4557</b>	
17. INFORMANT <b>Ronald K. Craven</b> ADDRESS <b>250 S. Maple #5 Oak Park, Ill.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive &amp; arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Diabetes mellitus</b>											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE  TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER										DATE SIGNED <b>4-18-86</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b> ADDRESS <b>111 Penn St., Balto., MD 21201</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b> 23b. DATE <b>4-21-86</b> 23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Anatomy Board Balto., Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>APR 22 1986</b> 25b. REGISTRAR'S SIGNATURE 	



00-03734

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				86 10588			
1- FOR STATE REGISTRAR <i>Item 11 A.L. 59-86 per phone</i>				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <i>Jerome CRAWFORD</i>				2a DATE OF DEATH MONTH DAY YEAR 4-13-86 2b HOUR 4 AM			
3 SEX <i>MALE</i>		4 RACE <i>BLACK</i>		5 DATE OF BIRTH MONTH DAY YEAR 6 7 34		6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>BALTIMORE</i>		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>CITY</i> MD.	
10 CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CEMENT FINISHER</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <i>MD</i>		13b COUNTY		13c CITY OR TOWN <i>BALTIMORE</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Gladys Thomas</i>		13e STREET ADDRESS / ZIP CODE <i>702 NEWINGTON AVE #17</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO <i>219-30-2797</i>		17 INFORMANT ADDRESS <i>MAY CRAWFORD 702 NEWINGTON AVE #17</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO RESPIRATORY ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPERTENSIVE CRISIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>PRIMA SCORDIA HEART DISEASE</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>DIABETES MELLITUS</i>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>4-3</i> 19 <i>86</i> , to <i>4-12</i> 19 <i>86</i> , that (I) (we) lost <i>4-11</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) <i>view the body after death</i> .							
22b SIGNATURE <i>[Signature]</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>4.13.86</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>ARTURO MIRANDA</i>				22e ADDRESS <i>1210 ST. Paul ST. Balt, Md 21202</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b DATE <i>4/18/86</i>		23c NAME OF CEMETERY OR CREMATORY <i>MT. ZION</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MD.</i>	
24 FUNERAL DIRECTOR NAME <i>WILLIAM C. BROWN</i> ADDRESS <i>Comm. F/H 1206-08 W. NORTH AVE</i>				25 DATE REC'D. BY REGISTRAR <i>APR 10 1986</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION





00-03771

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 5 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>(CROCKETT) HATTIE T. CROCKETT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4/11/86</b>		2b. HOUR <b>947</b> M	
3. SEX <b>F</b>		4. RACE <b>B.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 1 19</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House wife</b>		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <b>Md</b>				
13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William T. Ueney</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie Savoy</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-34-7067</b>		17. INFORMANT ADDRESS <b>Bernice Terry 3744 Crestfield Court</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 4-11 19 86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4-11 86 4-1 86</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>4-11 86</b> to <b>4-11 86</b> , that (I) (we) last saw the deceased alive on <b>4-11 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>E. Edwards Franco</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4/11/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Edwards Franco</b>		22e. ADDRESS <b>Sinai Hospital of Balto.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/17/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus Md</b>		24. FUNERAL DIRECTOR NAME <b>William C. March F/H West 4300 Wabash Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 16 1986</b>		
25b. REGISTRAR'S SIGNATURE <b>John Landon</b>						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

INVESTIGATION

REPORT

1. 2. 3. 4. 5.

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18. 19. 20. 21. 22.

23. 24. 25. 26. 27.

28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

10-04374

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10590

|                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                      |  |                                                                               |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------|--|-----------------|--|--------------------------------------|--|-------|--|----------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                               |  | FIRST                                                                                                                                                                                                |  | MIDDLE                                                                        |  | LAST                                                                |  | 2a. DATE KNOWN OF DEATH                      |  | MONTH           |  | DAY                                  |  | YEAR  |  | 7b. HOUR |  |      |  |          |  |
| Patricia Ann Crosby                                                                                                                                                                                                               |  |                                                                                                                                                                                                      |  |                                                                               |  |                                                                     |  | 4/ 16/ 86                                    |  |                 |  |                                      |  |       |  | 6:37 P M |  |      |  |          |  |
| SEX                                                                                                                                                                                                                               |  | 4. RACE                                                                                                                                                                                              |  | 5. DATE OF BIRTH                                                              |  | 6. AGE (IN YEARS)                                                   |  | IF UNDER 1 YR                                |  | IF UNDER 24 HRS |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH |  | DAY      |  | YEAR |  | 7d. HOUR |  |
| Female                                                                                                                                                                                                                            |  | Black                                                                                                                                                                                                |  | Jan. 29 - 53                                                                  |  | 33 YRS.                                                             |  |                                              |  |                 |  | 4/ 16/ 86                            |  |       |  |          |  |      |  | P M      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                         |  | 8. MARRIED                                                                    |  | NEVER MARRIED                                                       |  | WIDOWED                                      |  | DIVORCED        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |          |  |      |  |          |  |
| S.C.                                                                                                                                                                                                                              |  | U.S.A.                                                                                                                                                                                               |  |                                                                               |  |                                                                     |  |                                              |  |                 |  | Baltimore City,                      |  |       |  |          |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| Baltimore                                                                                                                                                                                                                         |  | Johns Hopkins Hospital                                                                                                                                                                               |  | Secretary                                                                     |  | Optical Co.                                                         |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| 13a. STATE                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                                                                                                                                          |  | 13c. CITY OR TOWN                                                             |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                          |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| Md                                                                                                                                                                                                                                |  |                                                                                                                                                                                                      |  | Baltimore                                                                     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 910 N. Caroline St. 21205                    |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                             |  |                                                                               |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| Carlisle                                                                                                                                                                                                                          |  | Fannie Mae Bondwell                                                                                                                                                                                  |  |                                                                               |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.                                                                                                                                                                             |  | 17. INFORMANT                                                                 |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| ?                                                                                                                                                                                                                                 |  | 212-60-7536                                                                                                                                                                                          |  | Carlisle Crosby                                                               |  | 2601 Oakley Ave.                                                    |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                         |  | PART I DEATH WAS CAUSED BY:                                                                                                                                                                          |  | IMMEDIATE CAUSE (a)                                                           |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
|                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                      |  | Sudden Cardiac Arrest                                                         |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
|                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                      |  | (b)                                                                           |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
|                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                      |  | (c)                                                                           |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I                                                                                                    |  |                                                                                                                                                                                                      |  |                                                                               |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                    |  | 20. AUTOPSY?                                                                  |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
|                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
|                                                                                                                                                                                                                                   |  | P.M. 19                                                                                                                                                                                              |  |                                                                               |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                                                          |  | 21f. LOCATION CITY OR TOWN                                                    |  | COUNTY                                                              |  | STATE                                        |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
|                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                      |  |                                                                               |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | THIS (SPECIFY)                                                                |  | M.D. Assistant                                                      |  | MEDICAL EXAMINER                             |  | DATE SIGNED     |  | 4/17/86                              |  |       |  |          |  |      |  |          |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                  |  | Dennis F. Smyth, M.D.                                                                                                                                                                                |  | ADDRESS                                                                       |  | 111 Penn St.                                                        |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                   |  |                                                                                                                                                                                                      |  |                                                                               |  |                                                                     |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                         |  | 23b. DATE                                                                                                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  | 23d. LOCATION CITY OR TOWN                                          |  | COUNTY                                       |  | STATE           |  |                                      |  |       |  |          |  |      |  |          |  |
| Burial                                                                                                                                                                                                                            |  | 4-21-86                                                                                                                                                                                              |  | Baltimore Cema                                                                |  | Baltimore                                                           |  |                                              |  | Md.             |  |                                      |  |       |  |          |  |      |  |          |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                         |  | ADDRESS                                                                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR                                                 |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |
| Randolph J. Tedlick                                                                                                                                                                                                               |  | 2431 E. Oliver St                                                                                                                                                                                    |  | APR 22 1986                                                                   |  | J. J. J. J. J.                                                      |  |                                              |  |                 |  |                                      |  |       |  |          |  |      |  |          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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00-04243

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 5 9 1  
REG. NO.

|                                                                                                                                                                                                                                                           |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                   |                                                                                                 |                                                                               |                                                                                                                                            |                                                 |                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CLAYTON ETHRIDGE CROSS</b>                                                                                                                                                                 |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 19 86</b>                  |                                                                                                                                                            |                                                                   | 2b. HOUR<br><b>7:15P M</b>                                                                      |                                                                               |                                                                                                                                            |                                                 |                                    |  |
| 1 SEX<br><b>Male</b>                                                                                                                                                                                                                                      |  | 4 RACE<br><b>White</b>                                                                                                                 |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 27 28</b>                                                                                                       |                                                                   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS                                                 |                                                                               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MINS                                                                                                  |                                                 |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |                                                                        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                 |                                                                               |                                                                                                                                            |                                                 |                                    |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |                                                                        |                                                                                                                                                            |                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Warehouse</b>            |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>A &amp; P Store</b>                                                                                |                                                 |                                    |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                             |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                        |                                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                      |                                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                               | 13e. STREET ADDRESS / ZIP CODE<br><b>662 Queensgate Road 21229</b>                                                                         |                                                 |                                    |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Cartel Cross</b>                                                                                                                                                                                              |  |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hazel Unknown</b>  |                                                                                                                                                            |                                                                   |                                                                                                 |                                                                               |                                                                                                                                            |                                                 |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                        |  | (IF YES, GIVE WAR OR DATES)<br><b>Korean</b>                                                                                           |                                                                        | 16b. SOCIAL SECURITY NO.<br><b>408-40-0379</b>                                                                                                             |                                                                   | 17 INFORMANT<br><b>Audrey F. Cross 662 Queensgate Road 21229</b>                                |                                                                               |                                                                                                                                            |                                                 |                                    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>                                                                                                      |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                   |                                                                                                 |                                                                               |                                                                                                                                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                                    |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Rheumatic mitral valve heart disease</b>                                                                              |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                   |                                                                                                 |                                                                               |                                                                                                                                            |                                                 |                                    |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                                     |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                   |                                                                                                 |                                                                               |                                                                                                                                            |                                                 |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                      |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                   |                                                                                                 |                                                                               |                                                                                                                                            |                                                 |                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                    |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                                 |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                  |  |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            |                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                                               |                                                                                                                                            |                                                 |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                            |  |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            |                                                                   | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                               |                                                                                                                                            |                                                 |                                    |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>4/19 86</b> to <b>4/18 86</b> that (1) we last saw the deceased alive on <b>4/19 86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                   |                                                                                                 |                                                                               |                                                                                                                                            |                                                 |                                    |  |
| 22b. SIGNATURE<br><b>Herbert J. Levickas</b>                                                                                                                                                                                                              |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                   | DEGREE<br><b>MD</b>                                                                             |                                                                               | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                 | 22c. DATE SIGNED<br><b>4/21/86</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Herbert J. Levickas</b>                                                                                                                                                                                       |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                   | 22e. ADDRESS<br><b>5404 East Drive</b>                                                          |                                                                               |                                                                                                                                            |                                                 |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                             |  |                                                                                                                                        | 23b. DATE<br><b>4/22/86</b>                                            |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b> |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge Howard Maryland</b> |                                                                                                                                            |                                                 |                                    |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>                                                                                                                                                                        |  |                                                                                                                                        |                                                                        |                                                                                                                                                            |                                                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 21 1986</b>                                             |                                                                               | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                           |                                                 |                                    |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. They please remove column papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

20% COTTON 1485K

100

11/11



100% COTTON 1485K

100

11/11

100

11/11

100

11/11

00-05435

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10592  
REG. NO.

|                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                 |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Walter Cissel Cross</b>                                                                                                                                                                                                                                                  |  |                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 27 86</b>                  |                                                                                                                                                             |                                                                  | 2b. HOUR<br><b>10:50 P.M.</b>                                                                   |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>Caucasian</b>                                                                                                                       |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 12 25</b>                                                                                                        |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS                                                |                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                                                                                                                            |                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                        |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen. Hospital</b> |                                                                        |                                                                                                                                                             |                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>             |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gen. Elec.</b>                                                                     |                                                                                                                                            |                                           |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                   |                                                                        | 13c. CITY OR TOWN<br><b>Catonsville</b>                                                                                                                     |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John T Cross</b>                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary E.</b>                                                                                   |                                                                        |                                                                                                                                                             |                                                                  | 16. STREET ADDRESS / ZIP CODE<br><b>188 Cherrydale Rd. 21228</b>                                |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>213201796</b>                                                                                                      |                                                                        | 17. INFORMANT<br><b>Mary Cross (wife)</b>                                                                                                                   |                                                                  | ADDRESS<br><b>188 Cherrydale Rd. Catonsville MD 21228</b>                                       |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b>                                                                                                                                                     |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                 |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 minutes</b>                                                          |                                                                                                                                            |                                           |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Ventricular Arrhythmias</b>                                                                                                                                           |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                 |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>End stage cardiac disease</b>                                                                                                                                                                                                                                          |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                 |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Lung Cancer with carcinomatosis</b>                                                                                                                                  |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                 |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| 19a. DATE OF OPERATION<br><b>4-7-86</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>4-7-86</b>      |                                                                                                                                                             |                                                                  | 20a. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |                                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            |                                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                        |  |                                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)                 |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                       |  |                                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| 22a. I certify that (I (this hospital) attended the deceased from <b>4-27-86</b> to <b>4-27-86</b> that (I (we) last saw the deceased alive on <b>4-27-86</b> and that (my (our) opinion death occurred on the date and hour and from the causes stated above.) (we) (did) (did not) view the body after death. |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                  |                                                                                                 |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| 22b. SIGNATURE<br><b>Mitchell F. Jelen, M.D.</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             | DEGREE<br><b>M.D.</b>                                            |                                                                                                 | 22c. DATE SIGNED<br><b>4-27-86</b>                                             |                                                                                                                            | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mitchell F. Jelen, M.D.</b>                                                                                                                                                                                                                                         |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>7001 S. Hanover St., Baltimore MD 21220</b>   |                                                                                                 |                                                                                |                                                                                                                            |                                                                                                                                            |                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                      |  |                                                                                                                                                   | 23b. DATE<br><b>1 MAY 86</b>                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CRESTLAWN MEM. GDN.</b> |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MARRIOTTSVILLE ITTAWA MD.</b> |                                                                                                                            |                                                                                                                                            |                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SLACK FUNERAL HOME ELLICOTT CITY, MD 21047</b>                                                                                                                                                                                                                       |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             | 25a. DATE REGISTERED<br><b>MAY 2 1986</b>                        |                                                                                                 |                                                                                |                                                                                                                            |                                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>1986</b> |  |

FEB

1843-1844

YES

With the committee

and



00-06058

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 10593

|                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------|------------------------------|-------------------------|--------|--------------------------------|---------------------------------------------------------------------|------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         | DECEASED NAME<br>(TYPE OR PRINT)                            |                                                                                                                                                             | FIRST                                                                         | MIDDLE                               | LAST                         | 2a. DATE KNOWN OF DEATH |        | <input type="checkbox"/> MONTH | <input checked="" type="checkbox"/> DAY                             | YEAR | 2b. HOUR                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         | Thelma                                                      |                                                                                                                                                             |                                                                               |                                      | Croswell                     | 4/28/1986               |        |                                |                                                                     |      | 9:40                                         |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE                                                                                                 | 5. DATE OF BIRTH                                            | 6. AGE (IN YEARS)                                                                                                                                           | IF UNDER 1 YR.                                                                | IF UNDER 24 HRS.                     | 2c. DATE PRONOUNCED DEAD     |                         | MONTH  |                                | DAY                                                                 | YEAR | 9:40                                         |
| F                                                                                                                                                                                                                                                                                                                                                                                                                                              | WHITE                                                                                                   | 8 3 1913                                                    | 72 YRS.                                                                                                                                                     |                                                                               |                                      | 4/30/1986                    |                         |        |                                |                                                                     |      | A M                                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH |                              |                         |        |                                |                                                                     |      |                                              |
| DELAWARE                                                                                                                                                                                                                                                                                                                                                                                                                                       | U.S.A.                                                                                                  |                                                             |                                                                                                                                                             |                                                                               | Baltimore City                       |                              |                         |        |                                |                                                                     |      |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY    |                              |                         |        |                                |                                                                     |      |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2000 O'Dell Ave.                                                                                        |                                                             | AT HOME                                                                                                                                                     |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                     | 13b. COUNTY                                                                                             | 13c. CITY OR TOWN                                           |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?                                                      | 13e. STREET ADDRESS                  |                              |                         |        |                                |                                                                     |      |                                              |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                            | BALTIMORE                                                                                               | BALTIMORE                                                   |                                                                                                                                                             | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           | 2000 O'DELL AVE, 21237               |                              |                         |        |                                |                                                                     |      |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         | 15. MOTHER'S MAIDEN NAME                                    |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         | FIRST MIDDLE LAST                                           |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| JOSEPH                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         | LEONA                                                       |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         | 16b. SOCIAL SECURITY NO.                                    |                                                                                                                                                             | 17. INFORMANT                                                                 |                                      | ADDRESS                      |                         |        |                                |                                                                     |      |                                              |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         | 215-10-8843                                                 |                                                                                                                                                             | FAMILY RECORDS                                                                |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| (b) _____                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| (c) _____                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| <u>Chronic Alcoholism</u>                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                | 20. AUTOPSY?                                                        |      |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                            |                                                                                                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                                      |                              |                         |        |                                |                                                                     |      |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         | P.M. 19                                                     |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                    |                                                                                                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION                                                                 |                                      |                              |                         |        |                                |                                                                     |      |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         |                                                             |                                                                                                                                                             | CITY OR TOWN COUNTY STATE                                                     |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural cause</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                                                                                                         |                                                             |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         | TITLE (SPECIFY)                                             |                                                                                                                                                             | DATE SIGNED                                                                   |                                      |                              |                         |        |                                |                                                                     |      |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         | M.D. Assistant MEDICAL EXAMINER                             |                                                                                                                                                             | 4/30/86                                                                       |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         | ADDRESS                                                     |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| Gregory R. Kauffman, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         | 111 Penn St.                                                |                                                                                                                                                             |                                                                               |                                      |                              |                         |        |                                |                                                                     |      |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         | 23b. DATE                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY                                            |                                      | 23d. LOCATION (CITY OR TOWN) |                         | COUNTY |                                | STATE                                                               |      |                                              |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         | 5-9-86                                                      |                                                                                                                                                             | GARDENS OF FAITH                                                              |                                      | LOSDORE                      |                         | BALTO. |                                | MD.                                                                 |      |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         | ADDRESS                                                     |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR                                                 |                                      | 25b. REGISTRAR'S SIGNATURE   |                         |        |                                |                                                                     |      |                                              |
| EVANS CHAPEL OF MEMORIES                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | 8800 HARFORD ROAD                                           |                                                                                                                                                             | MAY 9 1986                                                                    |                                      |                              |                         |        |                                |                                                                     |      |                                              |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM 1 PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

1915 August 20



1915 August 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This places removal of the body in legal order and should be handled with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**COPELAND**

**IMPORTANT:** If item 21 is marked or item 18 shows any injury or disease, the medical examiner must be notified.

IMPORTANT: If Item 21 is marked or Item 18 is not, only minor, if any, changes are allowed. The medical examiner must be notified if changes are made.

BP

DHMH - 16 60M 7/84  
(VRA 15. 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10594  
REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                |  |                                               |  |                                                                                                   |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-----------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------|--|---------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HELEN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | FIRST<br><b>C</b>                                                                                                                              |  | LAST<br><b>CROWE</b>                                                                                                                                        |  | 2a. DATE OF DEATH<br><b>APRIL 26,</b>                                                           |  | MONTH<br><b>1986</b>                                                           |  | 2b. HOUR<br><b>8:45</b>                       |  | P<br><b>M</b>                                                                                     |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>White</b>                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH <b>April</b> DAY <b>17</b> YEAR <b>1906</b>                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>                                                    |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                 |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b> |  |                                                                                                   |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                   |  |                                                                                |  |                                               |  | MD                                                                                                |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                               |  |                                               |  |                                                                                                   |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                |  | 13c. CITY OR TOWN<br><b>Middle River</b>                                                                                                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>28 Logwood Dr. 21220</b>                  |  |                                               |  |                                                                                                   |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST <b>George M.</b> MIDDLE <b>Herbert</b> LAST <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary E.</b> MIDDLE <b>Schaeffer</b> LAST <b></b>           |  |                                                                                |  |                                               |  |                                                                                                   |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>220 12 6887</b>                                                                                                 |  | 17. INFORMANT<br><b>19006 S Tyson Rd.<br/>Peggy May Mooney White Hall, Md. 21161</b>                                                                        |  |                                                                                                 |  |                                                                                |  |                                               |  |                                                                                                   |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>lung cancer and</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>renal failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b> |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                |  |                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>1 year</b><br><b>5 years</b> |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                |  |                                               |  |                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                        |  |                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                           |  |                                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) |  |                                               |  |                                                                                                   |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  |                                                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                               |  |                                                                                                   |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 10</b> , 19 <b>86</b> , to <b>April 26</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>April 26</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                      |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                |  |                                               |  |                                                                                                   |  | 22b. SIGNATURE<br><b>Susan Melley</b><br>DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/26/86</b> |  |                                                                           |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Susan Melley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |  | 22e. ADDRESS<br><b>The Johns Hopkins Hospital</b>                                                                                                           |  |                                                                                                 |  |                                                                                |  |                                               |  |                                                                                                   |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>4/30/86</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                                                                                              |  |                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore Co., Md.</b> COUNTY STATE           |  |                                               |  |                                                                                                   |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |
| 24. FUNERAL HOME<br><b>Bryczinski Funeral Home PA 1407 Old Eastern Ave</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 30 1986</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                               |  |                                               |  |                                                                                                   |  |                                                                                                                                                                                                         |  |                                    |  |                                                                           |  |                                                                                                                            |  |

00-02551

0-105388

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the deceased be in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, it should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                      |  |                                                                                                 |  | 86 10595<br>REG. NO.                                                                                                       |  |                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GLADYS CROWFFEY</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |  |                                                                                                                                                      |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 25, 1986</b>                                    |  |                                                                                                                            |  | 2b. HOUR<br><b>7:31 A.M.</b>                                                   |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>BLACK</b>                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 5 1923</b>                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS<br>HOURS MIN.                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |  |                                                                                                                            |  |                                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |                                                                                                                                                      |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                           |  |                                                                                |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                                                                                    |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2822 E. Federal St. Baltimore, Maryland 21213</b>                                     |  |                                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Moses Taliafero</b>                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Talifero</b>                                                                         |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No.</b>                                       |  | 16b. SOCIAL SECURITY NO.<br><b>216-32-8627</b>                                                  |  | 17. INFORMANT ADDRESS<br><b>Novel Taliafero Madison, Virginia</b>                                                          |  |                                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF,<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bowel infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                                                |  |                                                                                                                                                      |  |                                                                                                 |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 min</b><br><b>24 hrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                     |  |                                                                                                                                                |  |                                                                                                                                                      |  |                                                                                                 |  |                                                                                                                            |  |                                                                                |  |
| 19a. DATE OF OPERATION<br><b>4/24/86</b>                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bowel infarction</b>                                                                    |  |                                                                                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M.</b>                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                 |  |                                                                                                                            |  |                                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                 |  |                                                                                                                            |  |                                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/22</b> , 19 <b>86</b> , to <b>4/25</b> , 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>4/25</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |                                                                                                                                                |  |                                                                                                                                                      |  |                                                                                                 |  |                                                                                                                            |  |                                                                                |  |
| 22b. SIGNATURE<br><b>Joseph M. Sutton, M.D.</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>4/25/86</b>                                                                                         |  |                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH M. SUTTON, M.D.</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                |  | 22e. ADDRESS<br><b>600 N. WOLFE ST. BALTO., MD. 21205</b>                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |                                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>4/28/1986</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bolling Hill Ch. Cem.</b>                                                                                   |  |                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Amherst, Co. Virginia</b>                                                 |  |                                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Murphy &amp; Sons Funeral Home, Inc.<br/>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>                                                                                                                                                                                                                                 |  |                                                                                                                                                |  |                                                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 1 1986</b>                                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>                                                                      |  |                                                                                |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610596

REG. NO.

|                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----|----------------------------------------------------------------|----------|-------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                      |                                                                                                        | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                      |                                                               | FIRST                                                              | MIDDLE                            | LAST                                                                | 2a. DATE OF DEATH | MONTH                                                                                                                                      | DAY | YEAR                                                           | 2b. HOUR | A.M.  |
|                                                                                                                                                                                                                                                                                                                                             |                                                                                                        | TELKA CUNNINGHAM                                                                                                                                         |                                                               |                                                                    |                                   |                                                                     | APRIL 18 1986     |                                                                                                                                            |     |                                                                | 5:45     | M.    |
| 3. SEX                                                                                                                                                                                                                                                                                                                                      | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)                                    |                                   | IF UNDER 1 YEAR                                                     |                   | IF UNDER 72 HRS.                                                                                                                           |     |                                                                |          |       |
| FEMALE                                                                                                                                                                                                                                                                                                                                      | WHITE                                                                                                  | JAN. 3 1922                                                                                                                                              |                                                               | 64                                                                 |                                   | YRS.                                                                |                   | MONTHS                                                                                                                                     |     | DAYS                                                           |          | HOURS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                               |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| PENNA.                                                                                                                                                                                                                                                                                                                                      | U.S.A.                                                                                                 |                                                                                                                                                          |                                                               | BALTIMORE CITY                                                     |                                   | MD.                                                                 |                   |                                                                                                                                            |     |                                                                |          |       |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                   | 3631 ELMORA AVENUE                                                                                     |                                                                                                                                                          | INSPECTOR                                                     |                                                                    | CROWN, CORK & SEAL                |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 13b. COUNTY                                                                                                                                              |                                                               | 13c. CITY OR TOWN                                                  |                                   | 13d. INSIDE CITY LIMITS?                                            |                   | 13e. STREET ADDRESS / ZIP CODE                                                                                                             |     |                                                                |          |       |
| MD.                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                               | BALTIMORE                                                          |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   | 3631 ELMORA AVE. 21213                                                                                                                     |     |                                                                |          |       |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                               | 15. MOTHER'S MAIDEN NAME                                           |                                   |                                                                     |                   | ADDRESS                                                                                                                                    |     |                                                                |          |       |
| THOMAS RUSHETSKY                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                               | ANNA PROCHPUKA                                                     |                                   |                                                                     |                   | SAME ADDRESS                                                                                                                               |     |                                                                |          |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                               | 16b. SOCIAL SECURITY NO.                                           |                                   |                                                                     |                   | 17. INFORMANT                                                                                                                              |     |                                                                |          |       |
| NO                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                               | 178-12-8372                                                        |                                   |                                                                     |                   | ALEXANDER CUNNINGHAM (HUSBAND)                                                                                                             |     |                                                                |          |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| IMMEDIATE CAUSE (a) <u>multiple myeloma</u>                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| (b) _____                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| (c) _____                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |                                   |                                                                     |                   | 20a. AUTOPSY?                                                                                                                              |     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |       |
|                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                               | 21b. TIME OF INJURY                                                |                                   |                                                                     |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                              |     |                                                                |          |       |
|                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               | HOUR A.M. MONTH DAY YEAR                                           |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
|                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               | P.M. 19                                                            |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |                                   |                                                                     |                   | 21f. LOCATION                                                                                                                              |     |                                                                |          |       |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   | STREET CITY OR TOWN COUNTY STATE                                                                                                           |     |                                                                |          |       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1985</u> to <u>April 18, 1986</u> , that (I) (we) last saw the deceased alive on <u>March 15, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   |                                                                                                                                            |     |                                                                |          |       |
| 22b. SIGNATURE <u>Charles Padgett, MD</u>                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   | DEGREE                                                                                                                                     |     | 22c. DATE SIGNED                                               |          |       |
|                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |     | 4-18-86                                                        |          |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   | 22e. ADDRESS                                                                                                                               |     |                                                                |          |       |
| DR. CHAS. PADGETT                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   | GOOD SAMARITAN PROF. BLDG. SUITE 107                                                                                                       |     |                                                                |          |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               | 23b. DATE                                                          |                                   | 23c. NAME OF CEMETERY OR CREMATORY                                  |                   | 23d. LOCATION                                                                                                                              |     |                                                                |          |       |
| BURIAL                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                               | 4/21/86                                                            |                                   | OAK LAWN                                                            |                   | BALTIMORE COUNTY MD.                                                                                                                       |     |                                                                |          |       |
| 24. FUNERAL HOME, INC.                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |     | 25b. REGISTRAR'S SIGNATURE                                     |          |       |
| 3331 Brehms Lane, Balto. Md. 21213                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                               |                                                                    |                                   |                                                                     |                   | APR 21 1986                                                                                                                                |     | <u>John E. Anderson</u>                                        |          |       |

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1- STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                                                             |                                                                                              |                                                                                |                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------|
| DECEASED NAME<br>(TYPE OR WRITE) FIRST MIDDLE LAST<br><b>MARY M. Curry</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 24 86</b>                                        |                                                                                | 2b. HOUR<br>M<br><b></b>                                |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                  | RACE<br><b>Black</b>                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 24 24</b>                                                                                                        |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS HOURS MIN.<br><b>61</b>     |                                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>              |                                                         |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE MD</b>                                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS Hosp</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Disabled</b>          |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md</b> 13b. COUNTY <b></b> 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                                                                              |                                                                                                                                      |                                                                                                                                                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                |                                                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sell Johnson</b>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Inez Banks</b>                                                                                          |                                                                                              |                                                                                |                                                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>228-32-6527</b>                                                                                                              |                                                                                              | 17. INFORMANT<br>ADDRESS<br><b>Irving Curry, Jr 3217 Westmont Ave</b>          |                                                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic depletion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ISCHEMIC BRAIN SUSPECTED</b> |                                                                                                                                      |                                                                                                                                                             |                                                                                              |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CHRONIC RENAL FAILURE - depression</b>                                                                                                                                                                                                                   |                                                                                                                                      |                                                                                                                                                             |                                                                                              |                                                                                |                                                         |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                                         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                            |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                        |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                                                                       |                                                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                         |
| 22. I certify that (I) (this hospital) attended the deceased from <b>24 April 1986</b> to <b>24 April 1986</b> , that (I) (we) lost<br>saw the deceased alive on <b>24 April 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                                 |                                                                                                                                      |                                                                                                                                                             |                                                                                              |                                                                                |                                                         |
| 22a. SIGNATURE<br><b>Curtis E Dauls</b>                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      | DEGREE<br><b></b>                                                                                                                                           |                                                                                              | 22c. DATE SIGNED<br><b></b>                                                    |                                                         |
| 22b. PHYSICIAN'S NAME (TYPE OR WRITE)<br><b>Curtis E Dauls</b>                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      | 22e. ADDRESS<br><b>Bon Secours Hosp</b>                                                                                                                     |                                                                                              |                                                                                |                                                         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                      | 23b. DATE<br><b>4/28/86</b>                                                                                                                                 |                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ba H: More Nat Cem</b>                |                                                         |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>March F. H. West</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      | ADDRESS<br><b>4300 Wabash Avenue</b>                                                                                                                        |                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1986</b>                            |                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b></b>                                                                                                                       |                                                                                              |                                                                                |                                                         |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10598  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     |                                                                     |                                                                                                                                                            |                                    |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                                  |                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM J. CUSTER</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     | 7a DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 3, 1986</b>          |                                                                                                                                                            | 7b HOUR<br><b>6:20P M</b>          |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                                  |                  |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 4 RACE<br><b>White</b>                                                                                                              |                                                                     | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 7 1905</b>                                                                                                       |                                    | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>80</b> YRS.                                                                                                   |                                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                 |                                                                  | IF UNDER 72 HRS. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                        |                                                                     | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                                                                                      |                                                                                                |                                                                                                                           |                                                                  |                  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |                                                                     |                                                                                                                                                            |                                    | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bar Tender</b>                                                                 |                                                                                                |                                                                                                                           | 12b KIND OF BUSINESS OR INDUSTRY                                 |                  |  |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     | 13b COUNTY<br><b>Baltimore</b>                                      |                                                                                                                                                            | 13c CITY OR TOWN<br><b>Dundalk</b> |                                                                                                                                                      | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                           | 13e STREET ADDRESS / ZIP CODE<br><b>3426 Cornwall Road 21222</b> |                  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Custer</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hortons Barr</b> |                                                                                                                                                            |                                    |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                                  |                  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                 |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 208-07-6686</b>                                                  |                                                                     | 17 INFORMANT<br>ADDRESS<br><b>Francis L. Kushto Same as 13e</b>                                                                                            |                                    |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                                  |                  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RENAL FAILURE AND SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                     |                                                                     |                                                                                                                                                            |                                    |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                                  |                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>SEPSIS CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>                                                                                                                                                                                                        |  |                                                                                                                                     |                                                                     |                                                                                                                                                            |                                    |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                                  |                  |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                             |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |                                                                     |                                                                                                                                                            |                                    | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                  |                                                                                                | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                  |                  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                           |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |                                                                     | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                    |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                                  |                  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                          |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |                                                                     | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                    |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                                  |                  |  |
| 22 I certify that (I) (this hospital) attended the deceased from <b>MARCH 25, 1986</b> <b>APRIL 3, 1986</b> that (I) (we) last saw the deceased alive on <b>APRIL 3, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                          |  |                                                                                                                                     |                                                                     |                                                                                                                                                            |                                    |                                                                                                                                                      |                                                                                                |                                                                                                                           |                                                                  |                  |  |
| 23 SIGNATURE<br><b>A. F. Nazemi M.D.</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                     |                                                                     |                                                                                                                                                            |                                    | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                | 23c DATE SIGNED<br><b>4/9/86</b>                                                                                          |                                                                  |                  |  |
| 24 PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>XXXXXX A. F. NAZEMI MD.</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |                                                                     |                                                                                                                                                            |                                    | 24b ADDRESS<br><b>CHURCH HOSPITAL 100 NORTH BROADWAY 21231</b>                                                                                       |                                                                                                |                                                                                                                           |                                                                  |                  |  |
| 25a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                         |  | 25b DATE<br><b>4/7/1986</b>                                                                                                         |                                                                     | 25c NAME OF CEMETERY OR CREMATORY<br><b>Crownsville</b>                                                                                                    |                                    | 25d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Maryland</b>                                                                             |                                                                                                |                                                                                                                           |                                                                  |                  |  |
| 26 FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |                                                                     |                                                                                                                                                            |                                    | 26b ADDRESS<br><b>7922 Wise Avenue Dundalk, Maryland 21222</b>                                                                                       |                                                                                                | 26c DATE REC'D. BY REGISTRAR<br><b>APR 09 1986</b>                                                                        |                                                                  |                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     |                                                                     |                                                                                                                                                            |                                    | 26d REGISTRAR'S SIGNATURE<br><b>G. Davidson</b>                                                                                                      |                                                                                                |                                                                                                                           |                                                                  |                  |  |

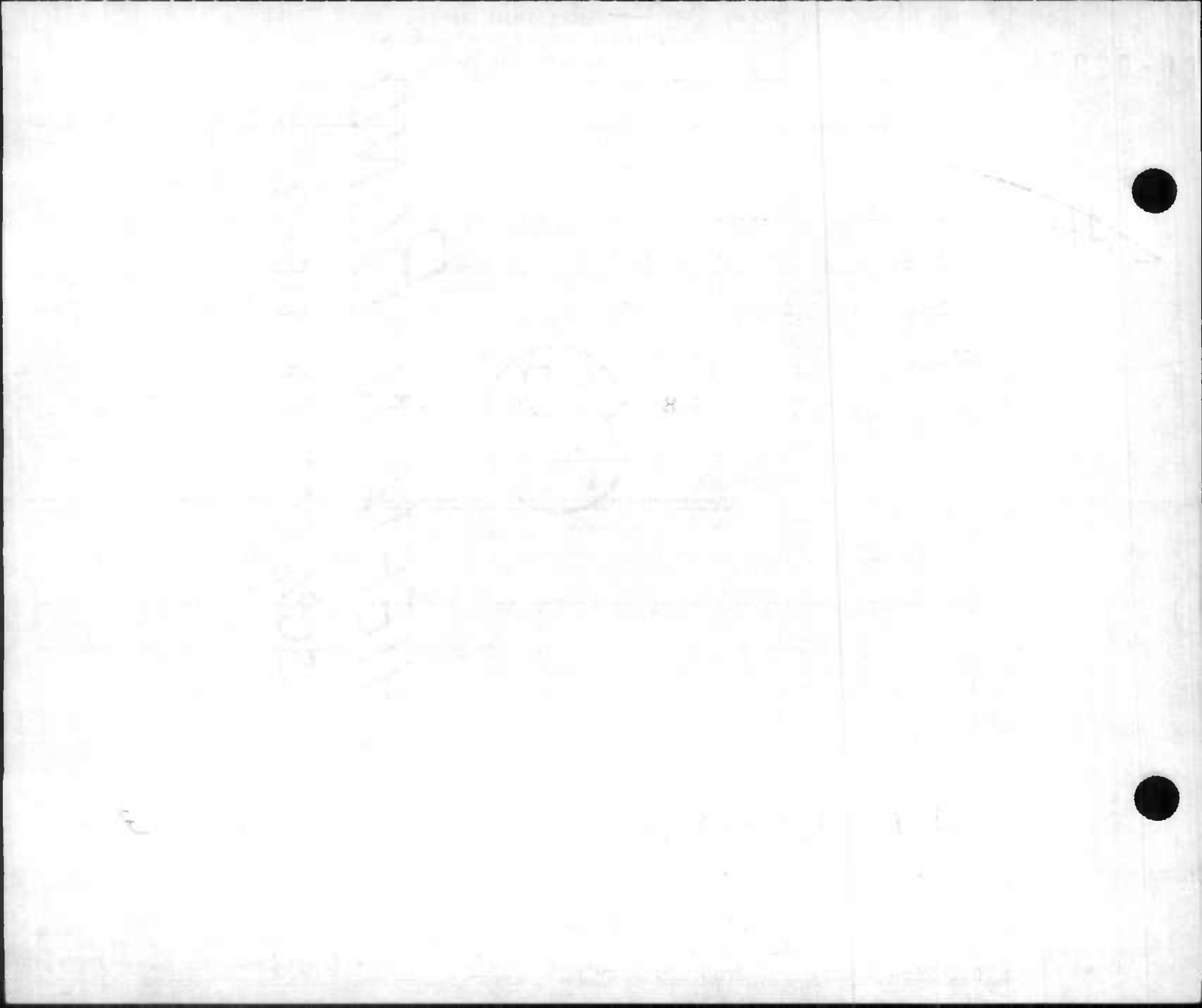
MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, enter any injury, or other traumatic event, the medical examiner will investigate.



00-04907

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Dock E. Cuzzart</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
| 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 21, 1986</b>                                                                                                                                                                                                                                                                                                                                              |  | 2b. HOUR<br><b>9.05 AM</b>                                                                                                                        |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 4 RACE<br><b>White</b>                                                                                                                            |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>7 11 1911</b>                                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>74</b>                                              |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                              |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Medical Center</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Coal Miner/Steel</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Worker-Beth.Steel</b>                                                           |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>                                                                                                                         |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1912 Frames Road 21222</b>                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Dock E. Cuzzart</b>                                                                                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Kathryn Oliver</b>                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                  |  |                                                                                              |  |                                                                                                                         |  |
| 16b. SOCIAL SECURITY NO.<br><b>400-09-4029</b>                                                                                                                                                                                                                                                                                                                                                         |  | 17 INFORMANT<br><b>Gladys Cuzzart</b>                                                                                                             |  |                                                                                                                                                             |  | ADDRESS<br><b>Same as 13e</b>                                                                |  |                                                                                                                         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>SEVERE COPD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>COAL MINER'S PNEUMOCONIOSIS</b> |  |                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>                                                                                                                                                                                                                  |  |                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                  |  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                              |  |                                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN. 29 19 74</b> to <b>APRIL 21 19 86</b> , that (I) (we) last saw the deceased alive on <b>FEB. 27 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                        |  |                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>T-J. PAGLINAUAN, MD</b>                                                                                                                                                                                                                                                                                                                                                           |  | DEGREE                                                                                                                                            |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |                                                                                              |  | 22c. DATE SIGNED<br><b>4-21-86</b>                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>T-J. PAGLINAUAN, MD</b>                                                                                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS<br><b>7811 WISE AVE., BALTO., MD 21237</b>                                                                                           |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>4/23/1986</b>                                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b>                                                                                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Dorsey Howard Maryland</b>                     |  | 23e. DATE REC'D. BY REGISTRAR<br><b>APR 28 1986</b>                                                                     |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Duda-Ruck, Inc.</b>                                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS<br><b>7922 Wise Avenue Dundalk, Maryland 21222</b>                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1986</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                   |  |                                                                                                                         |  |

BP



00-04278

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10600

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                  |  |                                                                                                                                      |                                                |                                                                                                                                                             |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LAHOMA B. CYRAN                                                           |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 21 86 |                                                                                                                                                             |  | 2b. HOUR<br>11 M                                                                                |  |
| 3. SEX<br>FEMALE                                                                                                 |  | 4. RACE<br>W                                                                                                                         |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 28 17                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WEST VIRGINIA                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. CITY                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>F.S. KEY MEDICAL CENTER |                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RET.                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD |  | 13b. COUNTY<br>BALTIMORE                                                                                                             |                                                | 13c. CITY OR TOWN<br>DUNDALK                                                                                                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SIMON BORROR                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FANNIE NINE                                                                         |                                                | 13e. STREET ADDRESS / ZIP CODE<br>304 OAKWOOD RD. 21222                                                                                                     |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                       |  | 16b. SOCIAL SECURITY NO.<br>234 387 986                                                                                              |                                                | 17. INFORMANT<br>ADDRESS<br>VICTOR CYRAN 304 Oakwood Rd.                                                                                                    |  |                                                                                                 |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST  
  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) ACUTE ANTERIOR MI

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
1 DAY

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

DIABETES MELLITUS

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                   |  |                                                                                      |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>21 APR 1986</u> , to <u>21 APR 1986</u> , that (I) (we) lost<br>saw the deceased alive on <u>21 APR 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                                                                                                   |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>C. T. MORROW</u>                                                                                                                                                                                                                                                                                                            |  | DEGREE <u>EMERG DEPT.</u><br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/><br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>21 APR 86                                                        |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. T. MORROW MD                                                                                                                                                                                                                                                                                         |  | 22e. ADDRESS<br>F.S. KEY EMERG DEPT, BALTO. 21224                                                                                                                                                                                 |  |                                                                                      |  |                                                                                                                            |  |

|                                                              |  |                      |  |                                                            |  |                                                              |  |
|--------------------------------------------------------------|--|----------------------|--|------------------------------------------------------------|--|--------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)                    |  | 23b. DATE<br>4/25/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART OF MARY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. CO. MD. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>KACZOROWSKI FUNERAL HOME     |  |                      |  | ADDRESS<br>2525 FLEET ST                                   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 22 1986                 |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Henderson</u> |  |                      |  |                                                            |  |                                                              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

35-81510

RECEIVED NOTICE

11/1/54  
[Faint, mostly illegible text follows, appearing to be a letter or report with several lines of handwriting.]



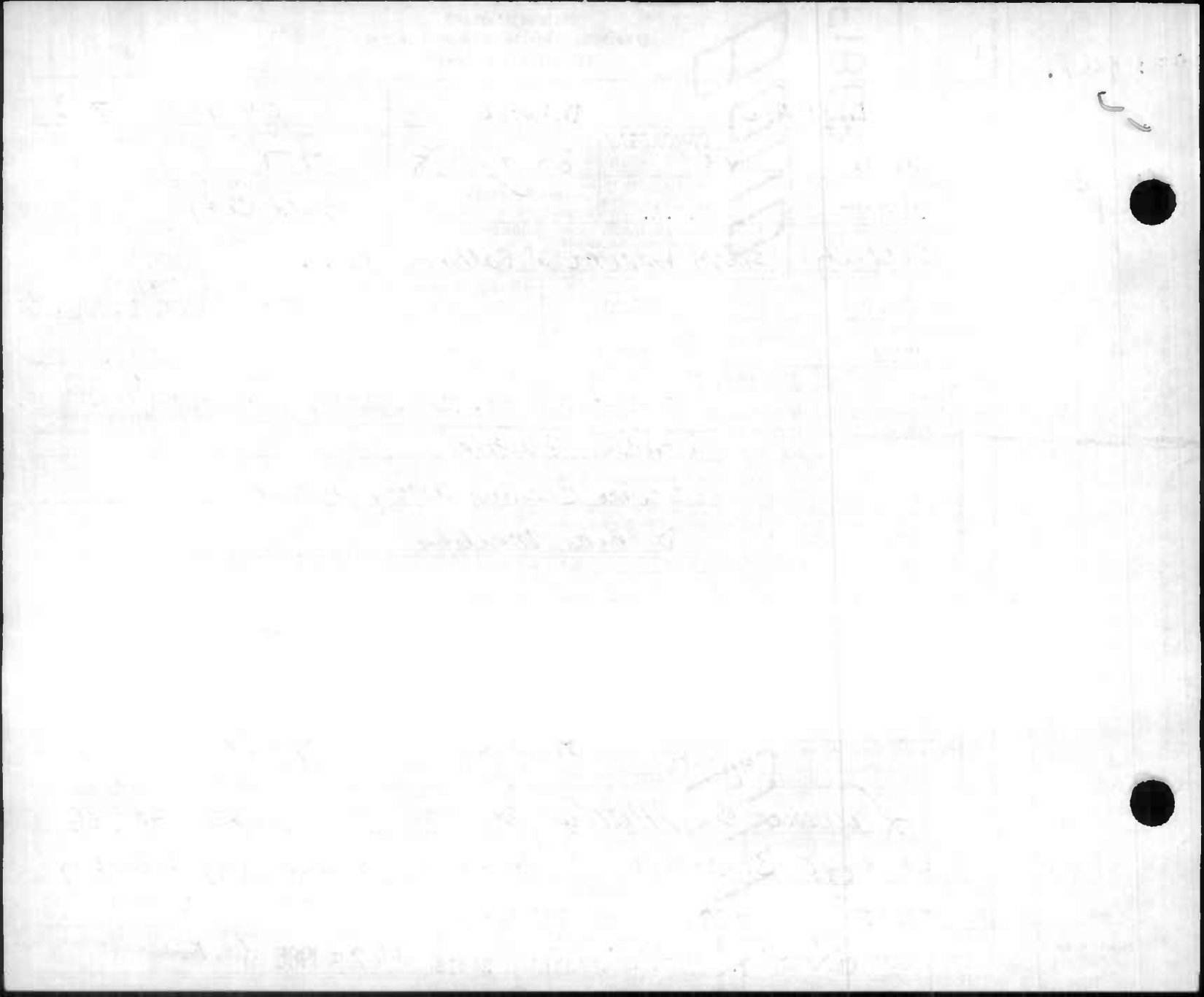
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610601  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                      |                                                                  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MICHAEL DANIEL</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 15 86</b>              |                                                                                                                                                             | 2b. HOUR<br><b>7<sup>58</sup> P.M.</b>                                               |                                                                  |                                                                                                                            |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                                     |                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 24 08</b>                                                                                                       |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>77</b> |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                   |                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Bald City</b> MD.     |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bald City</b>                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL of Baltimore</b> |                                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>C.P.A.</b>                                                                           |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ACCOUNTING</b>           |                                                                                                                            |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                 | 13b. COUNTY<br><b>BALTO</b>                                         |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>BALTO</b>                                                    |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HYMAN DANIEL</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE SIEDEL</b> |                                                                                                                                                             |                                                                                      |                                                                  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>212-18-4657</b>                                                                                                  |                                                                     | 17. INFORMANT<br>ADDRESS<br><b>MRS. FLORENCE DANIEL 6954 MILBROOK PARK DR. APT. 2C (21215)</b>                                                              |                                                                                      |                                                                  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Severe Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> |  |                                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                      |                                                                  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a                                                                                                                                                                                                                                                                   |  |                                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                      |                                                                  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |                                                                     |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                      |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                              |                                                                                      |                                                                  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/14/86</b> 19, to <b>4/15/86</b> 19, that (I) (we) last saw the deceased alive on <b>4/15/86</b> 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                                                                    |  |                                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                      |                                                                  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Laurence B. Marks MD</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                 |                                                                     | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                      | 22c. DATE SIGNED<br><b>4/15/86</b>                               |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAURENCE B. MARKS</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 |                                                                     | 22e. ADDRESS<br><b>6014 A Green Meadow Pkwy Baltimore 21209</b>                                                                                             |                                                                                      |                                                                  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>4/18/86</b>                                                                                                                     |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW MEM PARK</b>                                                                                              |                                                                                      | 23d. LOCATION<br><b>BALTIMORE MARYLAND</b> STATE                 |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                                 |                                                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 23 1986</b>                                                                                                         |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>       |                                                                                                                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10602

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                              |                                                                                                                                                             |                                                                                         |                                                                                                 |                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Vincent Paul D'ANTONI</b>                                                                                                                                                                                                                                                                                              |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4.26.86</b>                                                                                                       |                                                                                         | 2b. HOUR<br><b>4 P.M.</b>                                                                       |                                                                |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>White</b>                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 12 21</b>                                                                                                        |                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b><br>YRS. MONTHS DAYS HOURS MIN.                     |                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |                                                                |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>201 S. Clinton St. 21224</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Johnson Line Motor</b> |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                              | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Vincent D'ANTONI</b>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSA D'ANNA</b>                                                                                         |                                                                                         | 16. STREET ADDRESS / ZIP CODE<br><b>201 S. Clinton St. 21224</b>                                |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                    |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br><b>212-12-4291</b>                                                                                                              |                                                                                         | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Lola D'ANTONI 31234 St</b>                                  |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Diffuse Histocytic Lymphoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                              |                                                                                                                                                             |                                                                                         |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                  |                                                                                                                                              |                                                                                                                                                             |                                                                                         |                                                                                                 |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                          |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/2/86</b> 19 to <b>4/26/86</b> , that (I) (we) lost<br>saw the deceased alive on _____ 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                         |                                                                                                                                              |                                                                                                                                                             |                                                                                         |                                                                                                 |                                                                |
| 22b. SIGNATURE<br><b>Mohamed S. Al-Brahim</b>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                              | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                         | 22c. DATE SIGNED<br><b>4-28-86</b>                                                              |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mohamed S. Al-Brahim</b>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                              | 22e. ADDRESS<br><b>3901 Loch Raven Blvd Baltimore MD 21218</b>                                                                                              |                                                                                         |                                                                                                 |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                            |                                                                                                                                              | 23b. DATE<br><b>4-29-86</b>                                                                                                                                 |                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARRISON Vet. Cem.</b>                                 |                                                                |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                                                                                                                                                                                                                                                                                               |                                                                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 29 1986</b>                                                                                                         |                                                                                         |                                                                                                 |                                                                |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph N. ZANNINO Jr.</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                              | 25b. REGISTRAR'S SIGNATURE<br><b>2635. Conkling St</b>                                                                                                      |                                                                                         |                                                                                                 |                                                                |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



00-02812

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10603  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------|--|------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                              |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                               | 2a. DATE OF DEATH                                                                                                                          |                                   | MONTH DAY YEAR                                                 |  | 2b. HOUR         |                                              |
| Allen                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        | DAVIS, Sr.                                                                                                                                               |                                                               | 04-02-86                                                                                                                                   |                                   | 4 <sup>55</sup> P.M.                                           |  |                  |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                           | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |                                   | IF UNDER 1 YEAR                                                |  | IF UNDER 24 HRS. |                                              |
| MALE                                                                                                                                                                                                                                                                                                                                                             | BLACK AMERICAN                                                                                         | MONTH DAY YEAR<br>09 21 11                                                                                                                               |                                                               | 72 YRS.                                                                                                                                    |                                   | MONTHS DAYS                                                    |  | HOURS MIN.       |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |                                   |                                                                |  |                  |                                              |
| South Carolina                                                                                                                                                                                                                                                                                                                                                   | U.S.                                                                                                   |                                                                                                                                                          |                                                               | Baltimore City MD                                                                                                                          |                                   |                                                                |  |                  |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                |  |                  |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                        | Deaton Hospital & Medical Center                                                                       |                                                                                                                                                          |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                       | 13b. CITY OR TOWN                                                                                      | 13c. INSIDE CITY LIMITS?                                                                                                                                 | 13e. STREET ADDRESS / ZIP CODE                                |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| MD                                                                                                                                                                                                                                                                                                                                                               | Baltimore                                                                                              | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                      | 6117 Rich Ave 21228                                           |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| Peter J Davis                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | Unknown                                                                                                                                                  |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                               | 17. INFORMANT ADDRESS                                                                                                                      |                                   |                                                                |  |                  |                                              |
| 0                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 240 01-2448                                                                                                                                              |                                                               | Allen Davis, Jr. 615 N Ashburton St.                                                                                                       |                                   |                                                                |  |                  |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                   |                                                                |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic disease</u>                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>cardiac vascular accident</u>                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                               | 20a. AUTOPSY?                                                                                                                              |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                  |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                             |                                   |                                                                |  |                  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                           |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                               | 21f. LOCATION STREET                                                                                                                       |                                   | CITY OR TOWN                                                   |  | COUNTY           | STATE                                        |
|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> , 19 <u>84</u> , to <u>4/3</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | DEGREE                                                                                                                                                   |                                                               | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED                                               |  |                  |                                              |
| <u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                               |                                                                                                        | MD                                                                                                                                                       |                                                               |                                                                                                                                            |                                   | 4/3/86                                                         |  |                  |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                            |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                               |                                                                                                                                            |                                   |                                                                |  |                  |                                              |
| Greg Taylor                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | 22. S. Greene (Bald)                                                                                                                                     |                                                               | New                                                                                                                                        |                                   |                                                                |  |                  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                        |                                                                                                        | 23b. DATE                                                                                                                                                |                                                               | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                         |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |                  |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | 4/5/86                                                                                                                                                   |                                                               | Mt Auburn Cemetery                                                                                                                         |                                   | Baltimore, Maryland                                            |  |                  |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |                                   | 25b. REGISTRAR'S SIGNATURE                                     |  |                  |                                              |
| Law Funeral Home 4611 Park Heights Ave. 21215                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                               | APR 07 1986                                                                                                                                |                                   | <u>[Signature]</u>                                             |  |                  |                                              |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-5815

0-05427

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10604  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ernest Davis                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 30, 1986                                                                                                       |  | 2b. HOUR<br>7:15PM                                                                                                         |  |
| 3. SEX<br>M.                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br>B.                                                                                                                          |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 14 1914                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71<br>YRS. MONTHS DAYS                                                                  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Va.                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Security                                                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Laundry                                                                               |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                                            |  | 13c. CITY OR TOWN<br>Balto                                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hal Davis                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Helen Craighead                                                                  |  | 13e. STREET ADDRESS / ZIP CODE<br>2101 E. Federal ST. 21213                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-16-5955                                                                 |  | 17. INFORMANT<br>Mrs. C. G. Davis 2101 E. Federal ST.                                                                                                       |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Squamous Cell Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                          |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 26,</u> 19 <u>86</u> , to <u>April 30,</u> 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) lost <u>the deceased</u> above <u>the</u> (we) (did) (did not) view the body after death.                                                   |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Christopher D. Hogan M.D.                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |  | DEGREE<br>M.D.                                                                                                                                              |  | 22c. DATE SIGNED<br>4/30/86                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHRISTOPHER D. HOGAN                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  | 22e. ADDRESS<br>c/o Maryland General Hospital                                                                                                               |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>5-4-86                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Calvary Cem.                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rohoboth Va.                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Jas. A. Morten & Sons                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  | ADDRESS<br>1701 Laurens ST.                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 2 1986                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br>J. A. Morten                                                                                                                  |  |                                                                                                                            |  |

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00-04058

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be notified above.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

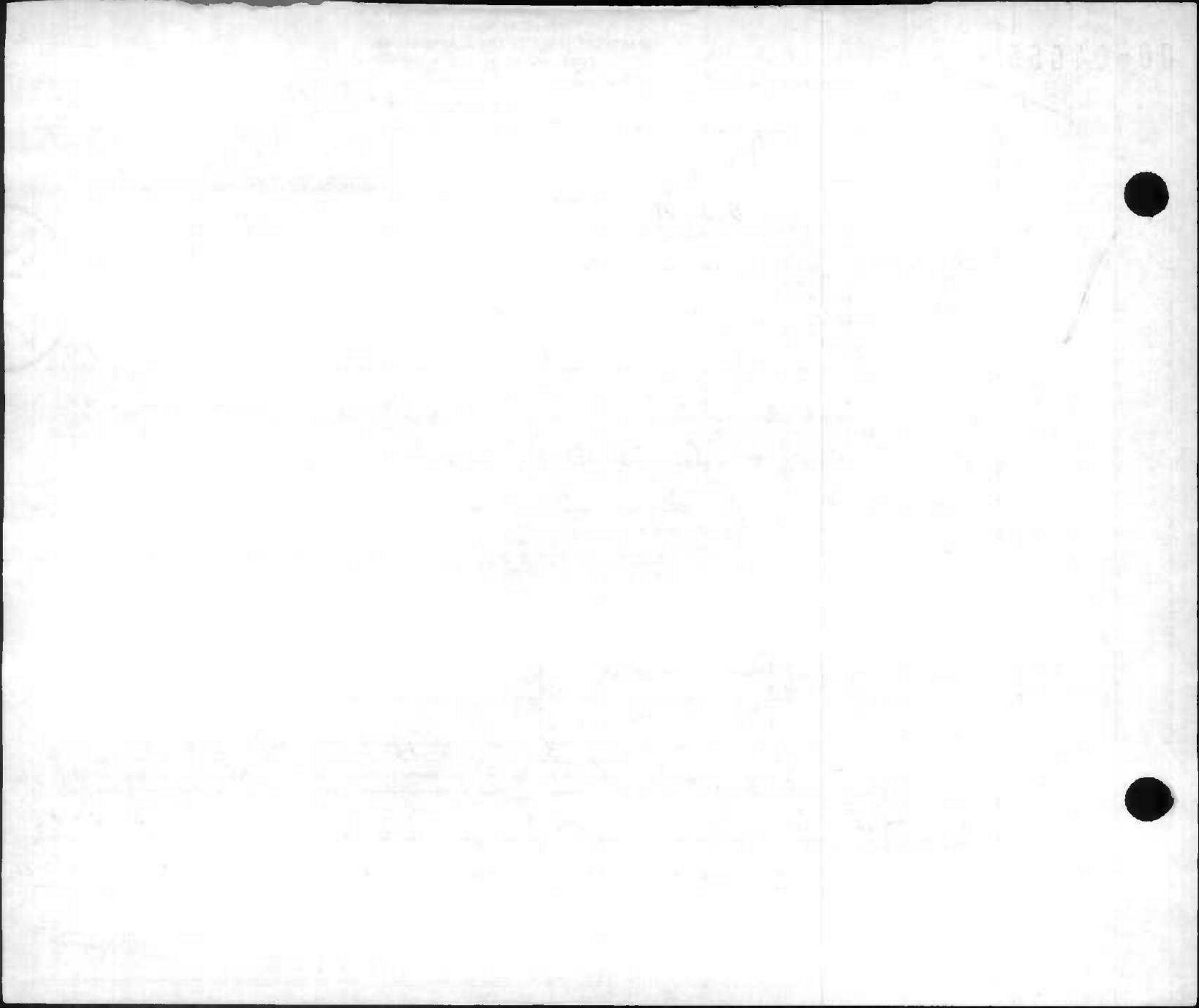
86

10605

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |                                                       |                                                                                                                                                             |  |                                                                                                                            |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EVA DAVIS</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 15 86</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>8:21</b><br>M                                                                                               |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>Black</b>                                                                                                                        |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 23 95</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b><br>YRS                                                                        |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                                           |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen. Hosp.</b> |                                                       |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>                                            |                                              |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br><b>MAA</b>                                                                                                                      |                                                       | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>VNK</b>                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>VNK</b>                                                                                    |                                                       | 16. SOCIAL SECURITY NO.<br><b>214383675</b>                                                                                                                 |  |                                                                                                                            |                                              |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>VNK</b>                                                                                                                                                                                                                                                    |  | 17b. SOCIAL SECURITY NO.<br><b>214383675</b>                                                                                                   |                                                       | 17. INFORMANT<br>ADDRESS<br><b>Blanche Wallace 225 Cedar Hill Lane 21225</b>                                                                                |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>b) <b>Severe ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                                                |                                                       |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                               |  |                                                                                                                                                |                                                       |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |                                                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                              |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that (1) this hospital attended the deceased from <b>3/26</b> , 19 <b>86</b> , to <b>4/15</b> , 19 <b>86</b> , that (1) (we) last saw the deceased alive on <b>4/15</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) we (did) (did not) view the body after death.    |  |                                                                                                                                                |                                                       |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br>                                                                                                                                                                                                                                                             |  | DEGREE<br><b>MD</b>                                                                                                                            |                                                       | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4-15-86</b>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Leonard M. Camm MD</b>                                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS<br><b>2001 S Hanover St Baltimore MD 21223</b>                                                                                    |                                                       |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>4 19-86</b>                                                                                                                    |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HALL U.M. CHURCH</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>GLEN BURNIE MARYLAND</b>                                                  |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WM.C.MARCH F/H INC.</b>                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br><b>1101 E. NORTH AVE.</b>                                                                                                           |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 18 1986</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br>        |                                              |

BP



00-05467

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

10606

|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GILBERT</b> <b>DAVIS JR.</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                               |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>30</b> YEAR <b>86</b>                                |                                                                                      | 2b. HOUR<br><b>2:50 P.M.</b>                                                                                               |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br><b>black</b>                                                                                                                       | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>22</b> YEAR <b>27</b>                                                                                             |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.                                    |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD                    |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANCIS SCOTT KEY MEDICAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>R.R. DEPT.</b>           |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BETH. STEEL</b>                                                                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                        |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                  | 13b. COUNTY                                                                                                                                   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>304 E. 20th STREET APT. B 21218</b>             |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST <b>GILBERT</b> MIDDLE LAST <b>DAVIS SR.</b>                                                                                                                                                                                                                                                                                                         |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>LUCIDA</b> MIDDLE LAST <b>BRADLEY</b>                                                                                  |                                                                                                 |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>215229702</b>                                                                                                                |                                                                                                 | 17. INFORMANT<br>ADDRESS<br><b>ALICE MCNUTT 304 E. 20th ST. APT. B</b>               |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>urmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>sepsis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>chronic renal failure, diabetes</b>                                                                                                                                                                                                       |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                       |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                           |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                      |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 15 1986</b> to <b>April 30 1986</b> , that (I) (we) lost saw the deceased alive on <b>April 30 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><b>Robert F. Committ</b>                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                               | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                                 | 22c. DATE SIGNED<br><b>4-30-86</b>                                                   |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert F. Committ</b>                                                                                                                                                                                                                                                                                                              |                                                                                                                                               | 22e. ADDRESS<br><b>FSK MC Eastern Ave B. 16, MD</b>                                                                                                         |                                                                                                 |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                               | 23b. DATE<br><b>5-5-86</b>                                                                                                                                  |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE</b>                               |                                                                                                                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                                                                                                                                                                                                                                                                                                        |                                                                                                                                               | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WM. C. MARCH F/H INC. 1101 E. NORTH AVE.</b>                                                                     |                                                                                                 |                                                                                      |                                                                                                                            |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 2 1986</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>J. H. DAVIS</b>                                                                                                            |                                                                                                 |                                                                                      |                                                                                                                            |

BP



100-04489

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10607

REG. NO.

|                                                                                                                                                                                                                                                                                                      |                                                                                                       |                                                                                                                                                         |                                                                                                                                            |                                      |                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                               |                                                                                                       | 2a DATE OF DEATH                                                                                                                                        |                                                                                                                                            | 2b HOUR                              |                                  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                      |                                                                                                       | 2a DATE OF DEATH                                                                                                                                        |                                                                                                                                            | 2b HOUR                              |                                  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                    |                                                                                                       | MONTH DAY YEAR                                                                                                                                          |                                                                                                                                            | HOUR MIN. AM PM                      |                                  |
| Julia Davis                                                                                                                                                                                                                                                                                          |                                                                                                       | April 19, 1986                                                                                                                                          |                                                                                                                                            | 9:10 A                               |                                  |
| 3 SEX                                                                                                                                                                                                                                                                                                | 4 RACE                                                                                                | 5 DATE OF BIRTH                                                                                                                                         | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                                             | 7a BALTIMORE CITY OR COUNTY OF DEATH |                                  |
| F                                                                                                                                                                                                                                                                                                    | B                                                                                                     | MONTH DAY YEAR                                                                                                                                          | 68 YRS.                                                                                                                                    | Baltimore City MD                    |                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                             | 7b CITIZEN OF WHAT COUNTRY?                                                                           | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                                        |                                      |                                  |
| N.C.                                                                                                                                                                                                                                                                                                 | U.S.A.                                                                                                |                                                                                                                                                         | Baltimore City MD                                                                                                                          |                                      |                                  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                             | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                         | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                               |                                      | 12b KIND OF BUSINESS OR INDUSTRY |
| Baltimore                                                                                                                                                                                                                                                                                            | Maryland General Hospital                                                                             |                                                                                                                                                         | N/A                                                                                                                                        |                                      |                                  |
| 13a STATE                                                                                                                                                                                                                                                                                            | 13b COUNTY                                                                                            | 13c CITY OR TOWN                                                                                                                                        | 13d INSIDE CITY LIMITS?                                                                                                                    | 13e STREET ADDRESS / ZIP CODE        |                                  |
| MARYLAND                                                                                                                                                                                                                                                                                             |                                                                                                       | BALTIMORE                                                                                                                                               | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        | 2037 GUILFORD AVE. 21218             |                                  |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                     | 15 MOTHER'S MAIDEN NAME                                                                               |                                                                                                                                                         | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                           |                                      |                                  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                    | FIRST MIDDLE LAST                                                                                     |                                                                                                                                                         | 16b SOCIAL SECURITY NO                                                                                                                     |                                      |                                  |
| WILLIAM WMS.                                                                                                                                                                                                                                                                                         | ISABELE AUSTIN                                                                                        |                                                                                                                                                         | 220-24-5521                                                                                                                                |                                      |                                  |
| 17 INFORMANT                                                                                                                                                                                                                                                                                         |                                                                                                       |                                                                                                                                                         | ADDRESS                                                                                                                                    |                                      |                                  |
| NO                                                                                                                                                                                                                                                                                                   |                                                                                                       |                                                                                                                                                         | JOHN DAVIS P.O. BOX 1136 PEARL CITY                                                                                                        |                                      |                                  |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b>                                                                                                                                              |                                                                                                       |                                                                                                                                                         |                                                                                                                                            |                                      |                                  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b>                                                                                                                                                                                                                                               |                                                                                                       |                                                                                                                                                         |                                                                                                                                            |                                      |                                  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                   |                                                                                                       |                                                                                                                                                         |                                                                                                                                            |                                      |                                  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)                                                                                                                                                                 |                                                                                                       |                                                                                                                                                         |                                                                                                                                            |                                      |                                  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 20a AUTOPSY?                                                                                                                                            | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                                                              |                                      |                                  |
|                                                                                                                                                                                                                                                                                                      |                                                                                                       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                      |                                  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                    | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                                                                                            |                                      |                                  |
|                                                                                                                                                                                                                                                                                                      | P.M. 19                                                                                               |                                                                                                                                                         |                                                                                                                                            |                                      |                                  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                              | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f LOCATION STREET                                                                                                                                     | CITY OR TOWN                                                                                                                               | COUNTY                               | STATE                            |
|                                                                                                                                                                                                                                                                                                      |                                                                                                       |                                                                                                                                                         |                                                                                                                                            |                                      |                                  |
| 22a I certify that (this hospital) attended the deceased from April 12, 1986 to April 19, 1986 that (we) lost (saw the deceased alive on April 19, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above.) (we) did not view the body after death. |                                                                                                       |                                                                                                                                                         |                                                                                                                                            |                                      |                                  |
| 22b SIGNATURE                                                                                                                                                                                                                                                                                        |                                                                                                       | DEGREE                                                                                                                                                  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED                      |                                  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                 |                                                                                                       | 22e ADDRESS                                                                                                                                             |                                                                                                                                            | 4/19/86                              |                                  |
| Jonathan S. Kushner                                                                                                                                                                                                                                                                                  |                                                                                                       | c/o Maryland General Hospital                                                                                                                           |                                                                                                                                            |                                      |                                  |
| 23a BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                       | 23b DATE                                                                                              | 23c NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d LOCATION CITY OR TOWN                                                                                                                  | COUNTY                               | STATE                            |
| BURIAL                                                                                                                                                                                                                                                                                               | 4-24-86                                                                                               | ARBUTUS                                                                                                                                                 | ARBUTUS                                                                                                                                    | MARYLAND                             |                                  |
| 24 FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                             |                                                                                                       | 25a DATE REC'D. BY REGISTRAR                                                                                                                            |                                                                                                                                            | 25b REGISTRAR'S SIGNATURE            |                                  |
| WM.C.MARCH F/H INC. 1101 E.NORTH AVE.                                                                                                                                                                                                                                                                |                                                                                                       | APR 23 1986                                                                                                                                             |                                                                                                                                            | John Davidson-Randall                |                                  |

0-6-00

April 1, 1940

Mr.

Mr.

Washington, D.C.

Harvard University

Cambridge, Mass.

Department of Education

Washington, D.C.

Harvard University

120

120

120

120

120

00-03988

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 0 6 0 8

REG. NO.

|                                                                                                               |  |                                                                                                                                                     |                                                       |                                                                                                                                                             |  |                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Viola DAWKINS</i>                              |  |                                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>4 14 86</i> |                                                                                                                                                             |  | 2b. HOUR<br><i>4 00</i>                                                                         |  |
| 3. SEX<br><i>Female</i>                                                                                       |  | 4. RACE<br><i>Black</i>                                                                                                                             |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9 23 17</i>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>68</i> YRS                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>South Carolina</i>                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                          |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore city</i> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lafayette Square Nursing Center</i> |                                                       |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><i>Maryland</i>                                                                                 |  | 13b. COUNTY<br><i>Baltimore</i>                                                                                                                     |                                                       | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>CASPER</i>                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>VINA</i>                                                                                        |                                                       | 16. STREET ADDRESS / ZIP CODE<br><i>501 Dolphin Street 21217</i>                                                                                            |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i> |  | 16b. SOCIAL SECURITY NO.<br><i>215 24 3593A</i>                                                                                                     |                                                       | 17. INFORMANT<br>ADDRESS<br><i>HAROLD DAWKINS Clifton Ave</i>                                                                                               |  |                                                                                                 |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *C.H.F.*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) *Ascend*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Pericardial Failure*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*4 yrs**4 yrs**1 month*PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *Diabetes*

|                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/12</i> 19 <i>73</i> to <i>4/13</i> 19 <i>86</i> , that (I) (we) last<br>saw the deceased alive on <i>4/10</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><i>Dr. M. M. Moore</i>                                                                                                                                                                                                                                                                                                                         |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>4/15/86</i>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>AMATUN MUHAMMAD</i>                                                                                                                                                                                                                                                                                                  |  |                                                                        |  | 22e. ADDRESS<br><i>501 Dolphin St. Balto MD 21217</i>                                                                                                |  |                                                                                                                               |  |

|                                                                                       |  |                             |  |                                                           |  |                                                                          |  |
|---------------------------------------------------------------------------------------|--|-----------------------------|--|-----------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>                         |  | 23b. DATE<br><i>4-18-86</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ARBUTUS MEM.</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTIMORE, MARYLAND</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>BROWN THOMPSON F.H. 1913 W. BALTO. ST.</i> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 18 1986</i>       |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

BP

1887-1888





00-03987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

10609

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                            |                                                                                                                                                                      |                                                                                     |                                                                                |                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ellsworth Dawson                                                                                                                                                                                                                                                                                                           |                                                                                                                            |                                                                                                                                                                      | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>4-15-86                                       |                                                                                | 2b HOUR<br>2:40AM                           |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                         | 4 RACE<br>B                                                                                                                | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>6/12/07                                                                                                                         |                                                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.                                      |                                             |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                                     | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |                                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALT. City MD.                          |                                             |
| 10 CITY OR TOWN OF DEATH<br>MD                                                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hosp |                                                                                                                                                                      | 12a USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING YRS)<br>Retired            |                                                                                | 12b KIND OF BUSINESS OR INDUSTRY<br>UNKNOWN |
| 13a STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                       | 13b COUNTY                                                                                                                 | 13c CITY OR TOWN<br>BALT.                                                                                                                                            | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                |                                             |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown                                                                                                                                                                                                                                                                                                                                      |                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown                                                                                                              |                                                                                     |                                                                                |                                             |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown                                                                                                                                                                                                                                                                                                        |                                                                                                                            | 16b SOCIAL SECURITY NO.<br>217-019225                                                                                                                                |                                                                                     | 17 INFORMANT<br>ADDRESS<br>Ethel Dawson (SAME)                                 |                                             |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Pulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) massive Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Renal failure |                                                                                                                            |                                                                                                                                                                      |                                                                                     |                                                                                |                                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>ASCUS                                                                                                                                                                                                                                            |                                                                                                                            |                                                                                                                                                                      |                                                                                     |                                                                                |                                             |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                            | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                      |                                                                                     | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                             |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                               |                                                                                                                            | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                            |                                                                                     | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) |                                             |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                         |                                                                                                                            | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                |                                                                                     | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |                                             |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                               |                                                                                                                            |                                                                                                                                                                      |                                                                                     |                                                                                |                                             |
| 22b SIGNATURE<br>Theresa R. Cruz                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                            | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                     | 22c DATE SIGNED<br>4-15-86                                                     |                                             |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rosita R. Cruz M.D.                                                                                                                                                                                                                                                                                                                           |                                                                                                                            | 22e ADDRESS<br>LUTHERAN HOSPITAL                                                                                                                                     |                                                                                     |                                                                                |                                             |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                 |                                                                                                                            | 23b DATE<br>4-19-86                                                                                                                                                  |                                                                                     | 23c NAME OF CEMETERY OR CREMATORY<br>ARBUSUS MEM. PK                           |                                             |
| 23d LOCATION<br>(CITY OR TOWN)<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                           |                                                                                                                            | 23e STATE<br>MARYLAND                                                                                                                                                |                                                                                     |                                                                                |                                             |
| 24 FUNERAL DIRECTOR<br>NAME<br>BROWN THOMPSON F.H.                                                                                                                                                                                                                                                                                                                                    |                                                                                                                            | 24b ADDRESS<br>1913 W. BALTO. ST.                                                                                                                                    |                                                                                     | 25a DATE REC'D. BY REGISTRAR<br>APR 18 1986                                    |                                             |
| 25b REGISTRAR'S SIGNATURE<br>Julia Davidson                                                                                                                                                                                                                                                                                                                                           |                                                                                                                            |                                                                                                                                                                      |                                                                                     |                                                                                |                                             |

*[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]*

00-03976

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

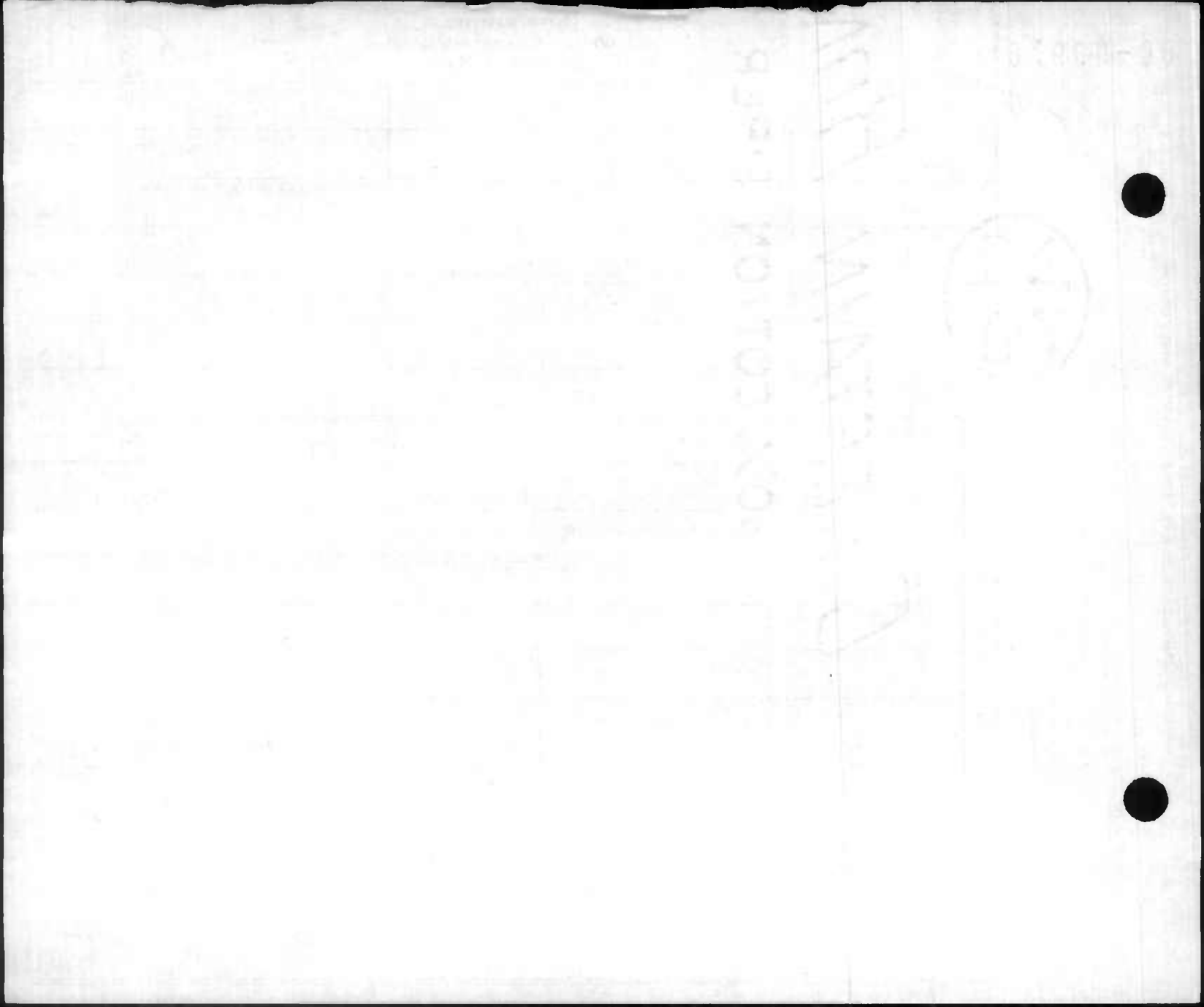
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                               |  |                                                                                                                              |  |                                                                                                                                                             |                                                    |                                                                                                                                                       |  |                                                                                                                         |  | 86 10610 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------|--|
| 1. FOR STATE REGISTRATION                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                              |  |                                                                                                                                                             |                                                    |                                                                                                                                                       |  |                                                                                                                         |  | REG. NO. |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Emma Day                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                              |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>April 16, 1986 |                                                                                                                                                       |  | 2b. HOUR<br>M                                                                                                           |  |          |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>Black                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 12 1886                                                                                                               |                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>99 YRS.                                                                                                            |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 72 HRS. HOURS MIN.                                                              |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                                             |  |                                                                                                                         |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3905 Colborne Road |  |                                                                                                                                                             |                                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |          |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                  |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                                    | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                          |  | 13e. STREET ADDRESS / ZIP CODE<br>3905 COLBORNE RD. 21229                                                               |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOHN BOONE                                                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>UNKNOWN                                                                        |  |                                                                                                                                                             |                                                    |                                                                                                                                                       |  |                                                                                                                         |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>220-30-5768                                                                                      |  | 17. INFORMANT ADDRESS<br>DELORES MURRY 318 N. CALHOUN STREET                                                                                                |                                                    |                                                                                                                                                       |  |                                                                                                                         |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                              |  |                                                                                                                                                             |                                                    |                                                                                                                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 min</u><br><u>2 years</u>                                          |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                             |  |                                                                                                                              |  |                                                                                                                                                             |                                                    |                                                                                                                                                       |  |                                                                                                                         |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |  |                                                                                                                                                             |                                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                    |                                                                                                                                                       |  |                                                                                                                         |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                    |                                                                                                                                                       |  |                                                                                                                         |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> 19 <u>86</u> to <u>4/16</u> 19 <u>86</u> , that (I) (we) lost <u>3:17</u> <u>PM</u> above (I) (we) (did not) view the body after death.                                                                                                                                                             |  |                                                                                                                              |  |                                                                                                                                                             |                                                    |                                                                                                                                                       |  |                                                                                                                         |  |          |  |
| 22b. SIGNATURE<br>Paul Katzenstein                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                              |  | DEGREE<br>MD                                                                                                                                                |                                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>4/16/86                                                                                             |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL KATZENSTEIN                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                              |  | 22e. ADDRESS<br>Johns Hopkins Hospital                                                                                                                      |                                                    |                                                                                                                                                       |  |                                                                                                                         |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>4-21-86                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MOUNT CALVARY                                                                                                         |                                                    | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                                                                         |  |                                                                                                                         |  |          |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                              |  | ADDRESS<br>1101 E. North Ave.                                                                                                                               |                                                    | 25a. DATE REC'D. BY REGISTRAR 18 APR 18 1986                                                                                                          |  |                                                                                                                         |  |          |  |

BP



00-02965

DIVISION OF VITAL RECORDS, 201 WESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 may be retained by the funeral director. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 4 Per phone call

1. FOR  
STATE  
REGISTRAR

4-15-86 A.L.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

10611

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |                                                                             |                                                                                                                                                                  |                                                                                                               |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HARRY WEAVER DECKER</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>APRIL 6, 1986</b>                    |                                                                                                                                                                  | 2b. HOUR P M<br><b>7:19 P</b>                                                                                 |                                                                                                                            |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 4 RACE<br><b>White</b><br><b>U.S.A.</b>                                                                                                 |                                                                             | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>3 15 22</b>                                                                                                                 |                                                                                                               | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>64 YRS.</b>                                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |                                                                             | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |                                                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                          |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chauffeur &amp; Mech. Trucking Co.</b>                                                       |                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                         | 13b. COUNTY<br><b>Baltimore</b>                                             |                                                                                                                                                                  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                         |                                                                                                                            |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Ray Glenn Decker</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Willa Weaver</b>           |                                                                                                                                                                  |                                                                                                               | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW II</b>          |
| 16b. SOCIAL SECURITY NO.<br><b>174-18-0381</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         | 17. INFORMANT ADDRESS<br><b>Mabel I. Decker 2345 Washington Blvd. 21230</b> |                                                                                                                                                                  |                                                                                                               |                                                                                                                            |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Peripheral vascular disease</b> |  |                                                                                                                                         |                                                                             |                                                                                                                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 3/4 hr</b><br><b>&gt; 5 years</b><br><b>&gt; 5 years</b> |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a<br><b>Cerebral vascular disease, probable embolism</b>                                                                                                                                                                                                                    |  |                                                                                                                                         |                                                                             |                                                                                                                                                                  |                                                                                                               |                                                                                                                            |
| 19a. DATE OF OPERATION<br><b>3/28/86</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Coronary &amp; carotid artery disease</b>                                        |                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                             |                                                                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                          |                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                   |                                                                                                               |                                                                                                                            |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |                                                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                   |                                                                                                               |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/6</b> 19 <b>86</b> , to <b>4/6</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/6</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.                                                       |  |                                                                                                                                         |                                                                             |                                                                                                                                                                  |                                                                                                               |                                                                                                                            |
| 22b. SIGNATURE<br><b>Andrew Lee</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |                                                                             | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                               | 22c. DATE SIGNED<br><b>4/6/86</b>                                                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Andrew Lee</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         |                                                                             | 22e. ADDRESS<br><b>Johns Hopkins Hospital, Balto, MD 21205</b>                                                                                                   |                                                                                                               |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>3/10/86</b>                                                                                                             |                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                                                                                                 |                                                                                                               | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brooklyn Pk. A.A. Maryland</b>                                               |
| 24 FUNERAL DIRECTOR NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |                                                                             | 25a. DATE RECEIVED BY REGISTRAR <b>APR 9 1986</b> 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                               |                                                                                                               |                                                                                                                            |

BP

A-7387-000  
W-V-946-43932  
5512180

00-03967

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10612  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                     |                                                                                                                                                             |                                                                                     |                                                                                |                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PAUL JOSEPH DECKRET</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 15, 1986</b>                        |                                                                                | 2b. HOUR<br>M<br><b>AM</b>                                                                                                    |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>WHITE</b>                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCTOBER 1, 1918</b>                                                                                                |                                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                   |                                                                                |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>106 N. ROSE ST.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MRS. SMITH'S</b>                       |                                                                                                                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                |                                                                                                                                     |                                                                                                                                                             | 13b. COUNTY<br><b>BALTIMORE</b>                                                     | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALFRED DECKRET</b>                                                                                                                                                                                                                                                                                         |                                                                                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARIE JANKOWSKI</b>             |                                                                                |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                      |                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR DATES)<br><b>WW II 216 01 7891</b>                                                                            |                                                                                     | 17. INFORMANT<br>ADDRESS<br><b>MARTHA M. DECKRET 106 N. ROSE ST.</b>           |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>                                                                                                                                                                                                  |                                                                                                                                     |                                                                                                                                                             |                                                                                     |                                                                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>SUDDEN</b>                                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>ARTERIO SCLEROTIC CARDIO-VASC DS.</b>                                                                                                                                                                                                           |                                                                                                                                     |                                                                                                                                                             |                                                                                     |                                                                                |                                                                                                                               |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                             |                                                                                     |                                                                                |                                                                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>CEREBRAL VASCULAR ACCIDENT</b>                                                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                             |                                                                                     |                                                                                |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                |                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                             |                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/25</b> 19 <b>84</b> to <b>4/15</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>2/15/85</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |                                                                                                                                     |                                                                                                                                                             |                                                                                     |                                                                                |                                                                                                                               |
| 22b. SIGNATURE<br><b>Irvin B. Kaplan MD</b>                                                                                                                                                                                                                                                                                                             |                                                                                                                                     | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                     | 22c. DATE SIGNED<br><b>4/16/86</b>                                             |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>IRVIN B. KAPLAN MD</b>                                                                                                                                                                                                                                                                                      |                                                                                                                                     | 22e. ADDRESS<br><b>129 S. BROADWAY 21231</b>                                                                                                                |                                                                                     |                                                                                |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                        | 23b. DATE<br><b>4-18-1986</b>                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS</b>                                                                                                 |                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>             |                                                                                                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>RAYMOND L. KACZOROWSKI</b>                                                                                                                                                                                                                                                                                           |                                                                                                                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 18 1986</b>                                                                                                         |                                                                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Davidson Kaplan</b>                      |                                                                                                                               |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

CC-0  
10-10  
10-10

Part of the 1000th Anniversary  
of the University of Chicago  
The University of Chicago Press  
Chicago, Illinois  
1957

1000th Anniversary  
of the University of Chicago  
The University of Chicago Press  
Chicago, Illinois  
1957



00-03391

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 6 1 3

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                              |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Margaret M. DeFrank</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 10, 1986</b>           |                                                                                                                                                             |                                                                                              | 2b. HOUR<br><b>10 A.M.</b>                                                           |                                                                                                                                            |                                                                                                                                       |                                    |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>White</b>                                                                                     |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 10, 1892</b>                                                                                                  |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b>                                         |                                                                                                                                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                                   |                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                               |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                     |                                                                                                                                            |                                                                                                                                       |                                    |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE FULL ADDRESS)<br><b>447 W. 24th Street</b> |                                                                        |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>         |                                                                                      |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |                                    |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                                       |  |                                                                                                             |                                                                        |                                                                                                                                                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Schrenker</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                             |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agnes D. Little</b>                      |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>215 16 2501</b>                         |                                                                                                                                                             |                                                                                              | 17. INFORMANT ADDRESS<br><b>Agnes D. Little 613 W. 36th St. 21211</b>                |                                                                                                                                            |                                                                                                                                       |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                        |  |                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                              |                                                                                      |                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yr.</b><br><b>20 yr.</b>                                                         |                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Hypertension disease</b>                                                                                                                                                                                                               |  |                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                              |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |  |                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |                                                                                                                                            |                                                                                                                                       |                                    |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                     |  |                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                                            |                                                                                                                                       |                                    |
| 22. I certify that (I) <del>was not</del> attended the deceased from <b>1955</b> , 19 <b>86</b> , to <b>4/10</b> 19 <b>86</b> , that (I) <del>was not</del> saw the deceased alive on <b>3/25</b> 19 <b>86</b> , and that in (my) <del>own opinion</del> death occurred on the date and hour and from the causes stated above. (I) <del>did not</del> view the body after death. |  |                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                              |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                    |
| 22b. SIGNATURE<br><b>Norman R. Freeman, Jr.</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                             |                                                                        |                                                                                                                                                             | DEGREE<br><b>MD</b>                                                                          |                                                                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                                       | 22c. DATE SIGNED<br><b>4/11/86</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Norman R. Freeman, Jr.</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                             |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>4300 N. Charles Street Baltimore, Md.</b>                                 |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                    |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                             | 23b. DATE<br><b>04/14 '86</b>                                          |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b>                           |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland 21227</b>                                                             |                                                                                                                                       |                                    |
| 24. FUNERAL DIRECTOR<br><b>Burgee-Henss Funeral Home, Baltimore, Md. 21211</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                             |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 11 1986</b>                                          |                                                                                      | 25b. REGISTRAR'S SIGNATURE                                                                                                                 |                                                                                                                                       |                                    |

MEDICAL CERTIFICATION

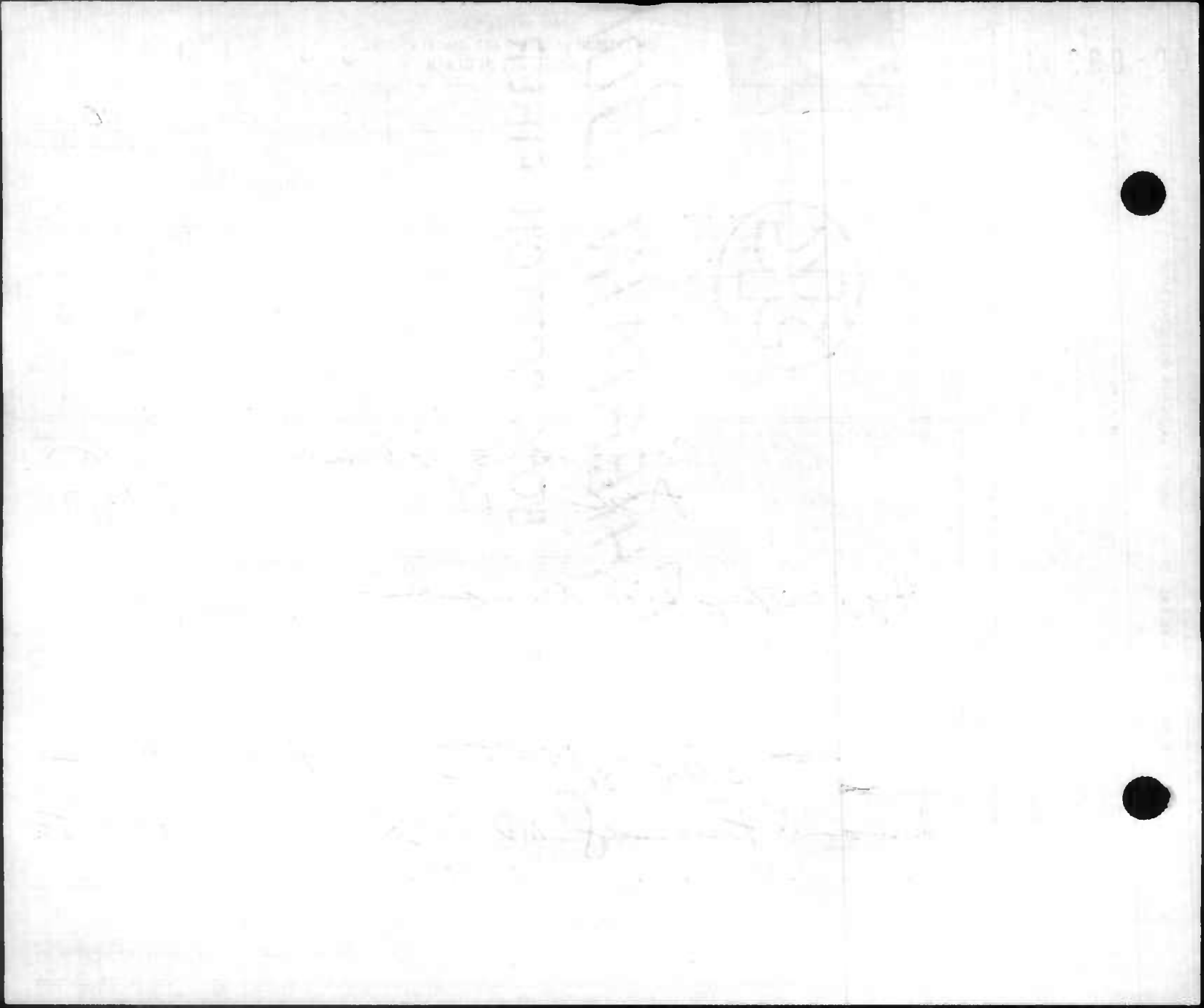
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by date.

BP



1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 6 1 4  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                        |                                                                                                                                                             |                                                                                            |                                                                                                 |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Samuel Joseph Deitz Sr.</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 4 1986</b>                                 |                                                                                                 | 2b. HOUR<br><b>7:30 PM</b>                                                                                                 |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                               | 4. RACE<br><b>Caucasian</b>                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 7 1913</b>                                                                                                    |                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance Man</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Alameda Shoppin</b>                                                                |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                        | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                             | 13c. CITY OR TOWN<br><b>Catonsville</b>                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2320 Powers Lane 21228</b>                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Deitz</b>                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Stump</b>                                                                                          |                                                                                            | 16. ADDRESS<br><b>2320 Powers Lane Catonsville Maryland</b>                                     |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-07-4455</b>                                                                               |                                                                                            | 17. INFORMANT<br><b>Mrs. Deora Deitz</b>                                                        |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>End stage congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____ |                                                                                                                                        |                                                                                                                                                             |                                                                                            |                                                                                                 |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                              |                                                                                                                                        |                                                                                                                                                             |                                                                                            |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                            |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                        |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-4 1986</b> to <b>4-4 1986</b> , that (I) (we) lost saw the deceased alive on <b>4-4 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                     |                                                                                                                                        |                                                                                                                                                             |                                                                                            |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><b>Jose Fernandez, M.D.</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                        | DEGREE                                                                                                                                                      |                                                                                            | 22c. DATE SIGNED<br><b>4-4-86</b>                                                               |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                        | 22e. ADDRESS<br><b>St Agnes Hosp. Catonsville, Balto, Md 21229</b>                                                                                          |                                                                                            |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                       | 23b. DATE<br><b>4/8/86</b>                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Old Salem Lutheran Cem.</b>                                                                                        |                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, Maryland 21133</b>                                                                                                                                                                                                                                                              |                                                                                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 07 1986</b>                                        |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

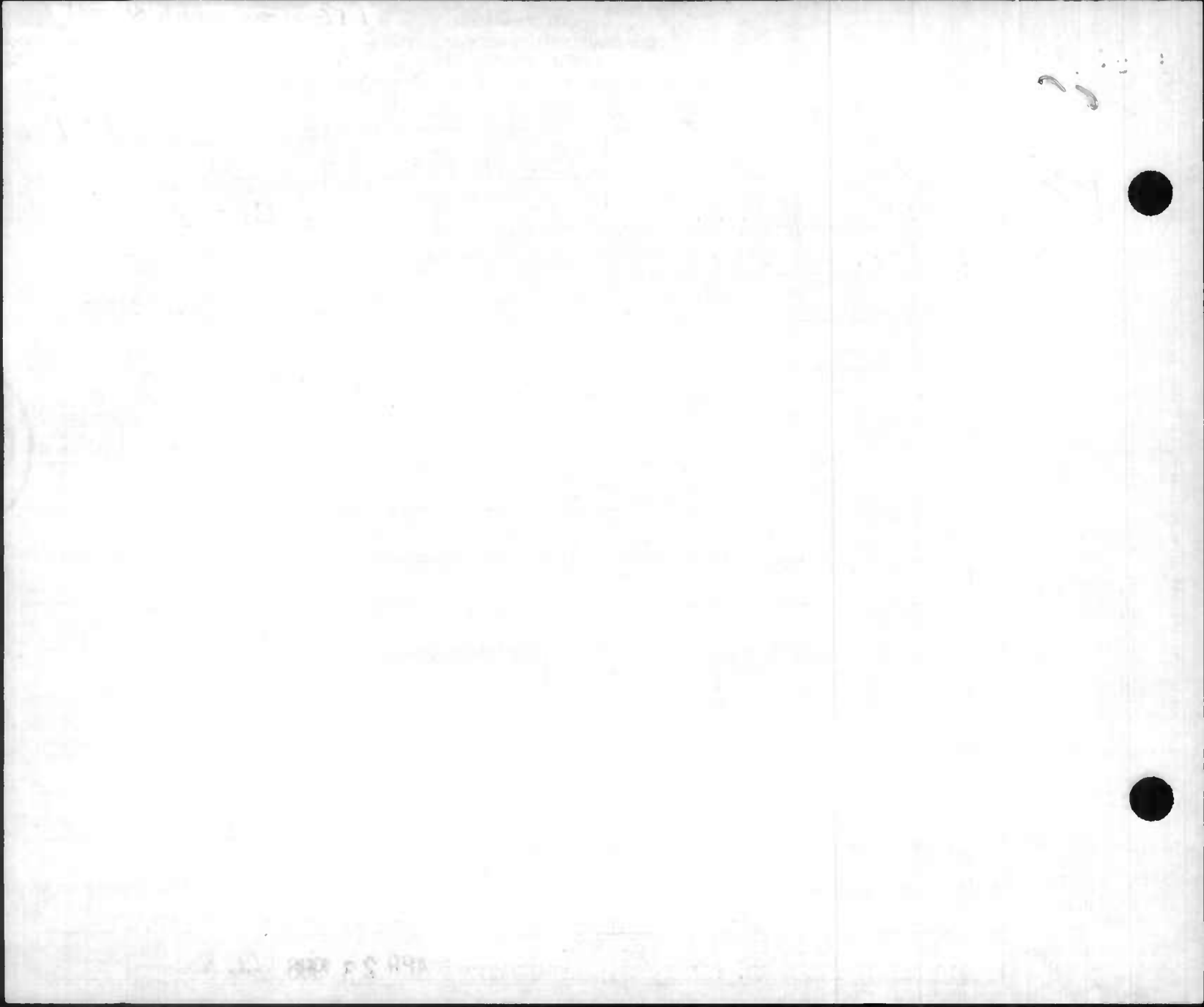
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These permits remove carbon papers. Pages 4 and 5, which are filled with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one of our

These are the only  
ones left of the original ones

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                             |                                                                               |                                                                                                        |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RAE E DELEVIE                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                             |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 16 86                                |                                                                                                        | 2b. HOUR<br>12 40 PM                         |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br>WHITE                                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 21, 1891                                                                                                         |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94                                                                  |                                              |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                                                |                                              |
| 10. CITY OR TOWN OF DEATH<br>BALTO.                                                                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH CHARLES GENERAL HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |                                                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                             |                                                                                                                                                             | 13b. CITY OR TOWN<br>BALTO.                                                   | 13c. STREET ADDRESS / ZIP CODE<br>524 N. CHARLES ST. 21201                                             |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN UNKNOWN                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CARRIE KING                                                                                                |                                                                               |                                                                                                        |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-03-3173                                                                                      |                                                                               | 17. IMPORTANT ADDRESS<br>ESTATE OF RAE E. DELEVIE (21202)<br>c/o CALMAN A. LEVIN 10 LIGHT ST 32nd FLR. |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) AORTIC STENOSIS & CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) COAGULOPATHY<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) SEPTICEMIA<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                                             |                                                                                                                                                             |                                                                               |                                                                                                        |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                   |                                                                                                                                             |                                                                                                                                                             |                                                                               |                                                                                                        |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                               |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                          |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                          |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                      |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/28 19 86, to 4/16 19 86, that (I) (we) last saw the deceased alive on 4/16 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                         |                                                                                                                                             |                                                                                                                                                             |                                                                               |                                                                                                        |                                              |
| 22b. SIGNATURE<br>A.C. CHOUVALIT, M.D.                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                             | DEGREE<br>M.D.                                                                                                                                              |                                                                               | 22c. DATE SIGNED<br>4/16/86                                                                            |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.C. CHOUVALIT, M.D.                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                             | 22e. ADDRESS<br>NCGH                                                                                                                                        |                                                                               |                                                                                                        |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                             | 23b. DATE<br>4/18/86                                                                                                                                        |                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>OHER SHALOM CEMETERY                                             |                                              |
| 23d. LOCATION<br>CITY OR TOWN<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             | COUNTY<br>BALTIMORE                                                                                                                                         |                                                                               | STATE<br>MARYLAND                                                                                      |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>APR 23 1986                                                                                                                |                                                                               | 25b. REGISTRAR'S SIGNATURE<br>Sol Levinson                                                             |                                              |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                             |                                                                                                                                                             |                                                                               |                                                                                                        |                                              |



00-06278

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10616  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         |                                                                                                                                                             |                                                                                     |                                                                                                 |                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RICHARD I. DE LONG                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 14, 1986                               |                                                                                                 | 2b. HOUR<br>4:15A M                                                                                                                   |
| 1 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                | 4 RACE<br>White                                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 9, 1940                                                                                                          |                                                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS.                                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Delaware                                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                     | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                       |                                                                                                                                       |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chief Custodian |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>School                                                                                           |
| 13a. STATE<br>De.                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         | 13b. COUNTY<br>Kent                                                                                                                                         | 13c. CITY OR TOWN<br>Felton                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>Nile St. 19943                                                                                      |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ira Delong                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl Marker                                                                                               |                                                                                     |                                                                                                 |                                                                                                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                            |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>222 24 0129                                                                                                                     |                                                                                     | 17 INFORMANT<br>Sharon Delong, Felton, De. 19943                                                |                                                                                                                                       |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>G (+)ve BACILLEMIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>MESOTHELIOMA</u> |                                                                                                                                         |                                                                                                                                                             |                                                                                     |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days.<br>3 weeks.                                                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>                                                                                                                                                                                                                                                   |                                                                                                                                         |                                                                                                                                                             |                                                                                     |                                                                                                 |                                                                                                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                     | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                     |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |                                                                                                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                 |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)                                                                                         |                                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/14/86</u> to <u>4/14/86</u> , that (I) (we) lost <u>4/14/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                           |                                                                                                                                         |                                                                                                                                                             |                                                                                     |                                                                                                 |                                                                                                                                       |
| 22b. SIGNATURE<br><u>Jimmy Sue</u>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | DEGREE<br>M-D<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                     | 22c. DATE SIGNED<br>4/14/86                                                                     |                                                                                                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JIMMY SUE, MD                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 22e. ADDRESS<br>St. Agnes Hospital, Md.                                                                                                                     |                                                                                     |                                                                                                 |                                                                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                          | 23b. DATE<br>4/18/86                                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Hopkins Cemetery                                                                                                      |                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Felton Kent De.                                   | 23e. DATE RECEIVED BY REGISTRAR<br>MAY 08 1986                                                                                        |
| 24 FUNERAL DIRECTOR<br>NAME<br>William A. Beatty Jr.                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                         | 25. DATE RECEIVED BY REGISTRAR<br>MAY 08 1986                                                                                                               |                                                                                     |                                                                                                 |                                                                                                                                       |

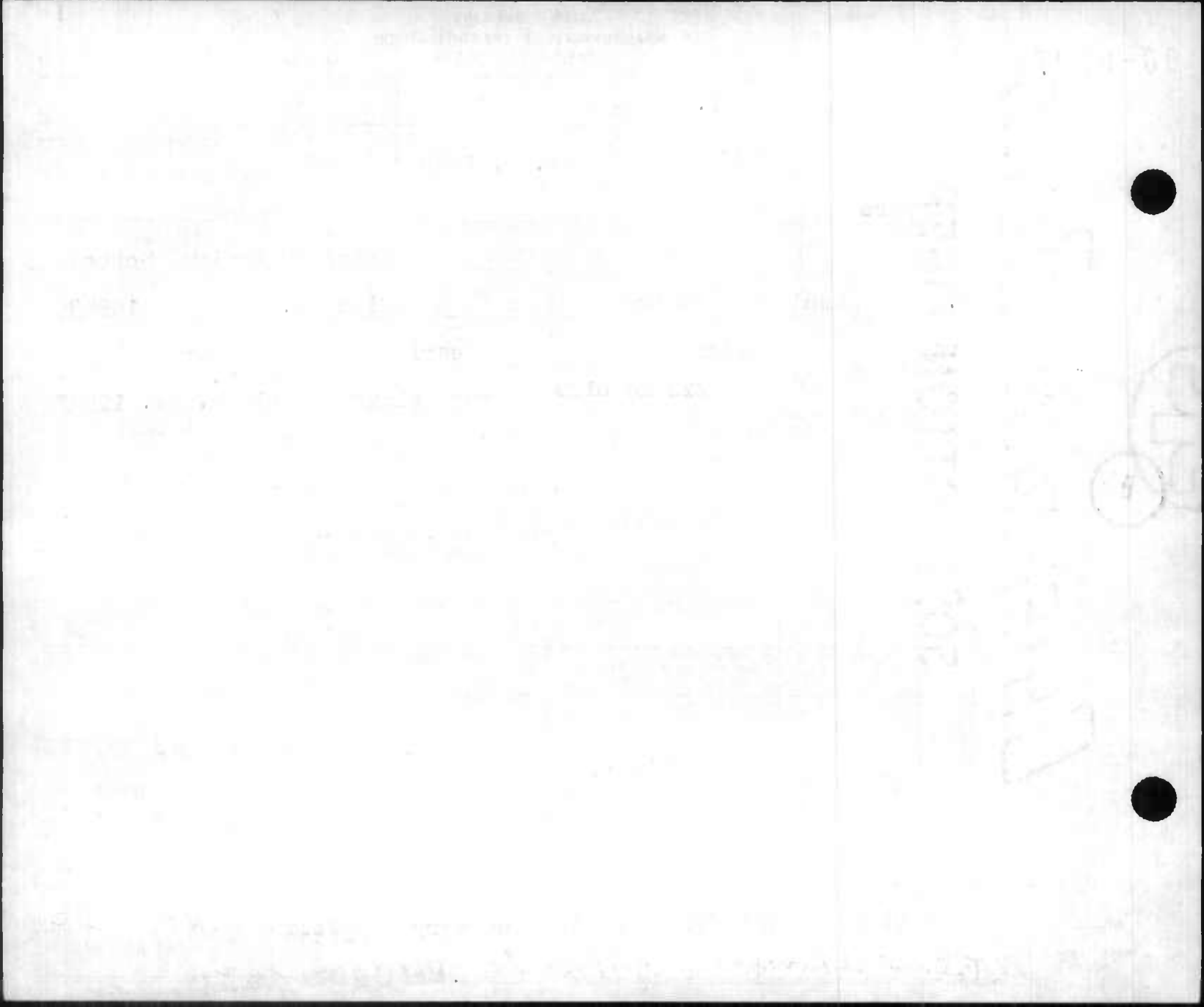
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked in item 18 above as injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610617

REG. NO.

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                                                 |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HETTIE G DEMBY</b>                                                                                                                                                                                                                                                                   |                                                                                                                                               |                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>TUESDAY APRIL 8 1986</b>                                                                                         |                                                                                                 | 2b. HOUR<br><b>11:10P<sub>M</sub></b>                                                                                      |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                              | 4 RACE<br><b>BLACK</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN. 28 1918</b>              |                                                                                                                                                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAROLINA</b>                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>                                                                                                |                                                                        | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                          |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3705 MILFORD AVENUE 21207</b> |                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>                                                                         |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NURSE ASSIST.</b>                                                                  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                             |                                                                                                                                               | 13b. COUNTY<br><b>BALTIMORE</b>                                        | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3705 MILFORD AVE. 21207</b>                                                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BOB ROBINSON</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNIE CHANDLER</b> |                                                                                                                                                            |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                       |                                                                                                                                               | 16b. SOCIAL SECURITY NO<br><b>214 16 51434</b>                         |                                                                                                                                                            | 17. INFORMANT<br>ADDRESS<br><b>MRS. EULA M. PERRY 3705 MILFORD AVE. 21207</b>                   |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CVA</b>                                                                                                                                                                                                             |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 days</b>                                                           |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Diabetes</b>                                                                                                                                                                                             |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                                                 | <b>1/2</b>                                                                                                                 |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                                                                                                                               |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                                                 |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                                    |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                              |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                            |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                           |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |                                                                                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (this hospital) attended the deceased from <b>3/14</b> 19 <b>86</b> , to <b>4/8/86</b> 19 <b>86</b> , that (we) last saw the deceased alive <b>3/14</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><b>Kenneth M. Zonis MD</b>                                                                                                                                                                                                                                                                                                        |                                                                                                                                               | DEGREE<br><b>MD</b>                                                    |                                                                                                                                                            | 22c. DATE SIGNED<br><b>4/10/86</b>                                                              |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KENNETH ZONIES</b>                                                                                                                                                                                                                                                                                      |                                                                                                                                               | 22e. ADDRESS<br><b>1777 Reisterstown Rd Pikesville MD</b>              |                                                                                                                                                            |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                       | 23b. DATE<br><b>4/14/86</b>                                                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MARYLAND NAT MEM PK</b>       |                                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LAUREL (PR. GEO.) MD.</b>                      |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEWIS T. GWYNN</b>                                                                                                                                                                                                                                                                                               |                                                                                                                                               | ADDRESS<br><b>4517 PARK HEIGHTS AVE.</b>                               |                                                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 10 1986</b>                                             |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                               |                                                                        |                                                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                      |                                                                                                                            |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will have to be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8610618  
REG. NO.

|                                                                                                                                                                                                                                                                                                                |                                                                    |                                                                                                       |                                                                       |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------|----------------------------------------------|-----|-------------------------------------------|----------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                         |                                                                    | 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                    |                                                                       | FIRST                                                                                                                                                   | MIDDLE                                                                                                                 | LAST                                                         | 2a DATE OF DEATH                | MONTH                                        | DAY | YEAR                                      | 2b HOUR  |
|                                                                                                                                                                                                                                                                                                                |                                                                    | WILLIAM                                                                                               |                                                                       |                                                                                                                                                         |                                                                                                                        | DEMCHENKO                                                    | 04                              | 30                                           | 86  |                                           | 855 P.M. |
| 3 SEX                                                                                                                                                                                                                                                                                                          | Male                                                               | 4 RACE                                                                                                | White                                                                 | 5 DATE OF BIRTH                                                                                                                                         | 11-30-1917                                                                                                             |                                                              | 6 AGE (IN YEARS LAST BIRTHDAY)  | 68                                           |     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |          |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                       | New York                                                           | 7b CITIZEN OF WHAT COUNTRY?                                                                           | USA                                                                   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |                                                              | BALTIMORE CITY MD.              |                                              |     |                                           |          |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                       | BALTIMORE City                                                     | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                       | UNION MEMORIAL HOSPITAL                                                                                                                                 |                                                                                                                        | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Letter Carrier                  |                                              |     |                                           |          |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                    | MD                                                                 | 13b COUNTY                                                                                            | Harford                                                               | 13c CITY OR TOWN                                                                                                                                        | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                                              | 13e STREET ADDRESS / ZIP CODE   |                                              |     |                                           |          |
|                                                                                                                                                                                                                                                                                                                |                                                                    |                                                                                                       |                                                                       |                                                                                                                                                         |                                                                                                                        | 620 Shore Drive, Joppa, MD 21085                             |                                 |                                              |     |                                           |          |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                               | Harry                                                              | 15 MOTHER'S MAIDEN NAME                                                                               | Anastia Prezlock                                                      |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                               | Yes                                                                | 16b SOCIAL SECURITY NO.                                                                               | WW II Army                                                            |                                                                                                                                                         | 704-01-6119                                                                                                            | 17 INFORMANT                                                 | Joan Demchenko, 620 Shore Drive |                                              |     |                                           |          |
| 18 CAUSE OF DEATH                                                                                                                                                                                                                                                                                              |                                                                    | Enter only one cause per line for (a), (b), and (c). Joppa, MD 21085                                  |                                                                       |                                                                                                                                                         |                                                                                                                        |                                                              |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |     |                                           |          |
| PART 1. DEATH WAS CAUSED BY                                                                                                                                                                                                                                                                                    |                                                                    | 8809 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST                                                      |                                                                       |                                                                                                                                                         |                                                                                                                        |                                                              |                                 | IMMEDIATE                                    |     |                                           |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                 |                                                                    | b) SEVERE CEREBRAL CONTUSION (MULTIPLE)                                                               |                                                                       |                                                                                                                                                         |                                                                                                                        |                                                              |                                 | 4 DAYS                                       |     |                                           |          |
|                                                                                                                                                                                                                                                                                                                |                                                                    | c) BRAIN HERNIATION                                                                                   |                                                                       |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                            |                                                                    |                                                                                                       |                                                                       |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                          | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                       | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                                         | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                              |                                 |                                              |     |                                           |          |
| 21a ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                    | 21b TIME OF INJURY                                                 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                          |                                                                       |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
|                                                                                                                                                                                                                                                                                                                | 8:30 P.M. 04 26 1986                                               | FALL DOWN 15 STAIRS                                                                                   |                                                                       |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| 21d INJURY OCCURRED                                                                                                                                                                                                                                                                                            | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION                                                                                          |                                                                       | STATE                                                                                                                                                   |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                   | HOME                                                               | 3803 OVERLEA AVE BALTIMORE                                                                            |                                                                       | MD 21206                                                                                                                                                |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| 22a I certify that (I) (this hospital) attended the deceased from 4/26, 1986, to 4/30, 1986, that (I) (we) lost saw the deceased alive on 4/30, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                    |                                                                                                       |                                                                       |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| 22b SIGNATURE                                                                                                                                                                                                                                                                                                  | DEGREE                                                             |                                                                                                       | 22c DATE SIGNED                                                       |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| William A. Jiranek                                                                                                                                                                                                                                                                                             |                                                                    |                                                                                                       | 4/30/86                                                               |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                           | 22e ADDRESS                                                        |                                                                                                       | 22f. DATE REC'D. BY REGISTRAR                                         |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| WILLIAM A. JIRANEK                                                                                                                                                                                                                                                                                             | 201 E. UNIV. PKWY BALTIMORE MD                                     |                                                                                                       | MAY 6 1986                                                            |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                       | 23b DATE                                                           | 23c NAME OF CEMETERY OR CREMATORY                                                                     | 23d LOCATION                                                          |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| Burial                                                                                                                                                                                                                                                                                                         | 5-5-86                                                             | Holy Redeemer                                                                                         | Balto. COUNTY MD                                                      |                                                                                                                                                         |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| 24 FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                       |                                                                    | 25a DATE REC'D. BY REGISTRAR                                                                          |                                                                       | 25b REGISTRAR'S SIGNATURE                                                                                                                               |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |
| John C. Miller, Inc., 6415 Belair Rd. 21206                                                                                                                                                                                                                                                                    |                                                                    | MAY 6 1986                                                                                            |                                                                       | John C. Miller, Inc.                                                                                                                                    |                                                                                                                        |                                                              |                                 |                                              |     |                                           |          |

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2002 JULY 11

2002 JULY 11

0-04582

Released on Approval by Medical Examiner  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

4-16-86 8:45am Dr. Ann Dixon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                       |                                                                                                                                                                                                                                                                                                                                                |                            |                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                       |                                                                                                                                                                                                                                                                                                                                                |                            |                                                             |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JERRY DENEAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                      |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/16/86</b> |                                                                                                                                                                                                                                                                                                                                                | 2b. HOUR<br><b>4:05 AM</b> |                                                             |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>Black</b>                                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 06 24</b>                                                                                                       |                                                       | 6. AGE (IN YEARS) (LAST BIRTHDAY)<br><b>61</b>                                                                                                                                                                                                                                                                                                 |                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                                                                                                                                                                                                                                                             |                            |                                                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Medical Center</b> |  |                                                                                                                                                             |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>                                                                                                                                                                                                                                                             |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                       |                                                                                                                                                                                                                                                                                                                                                |                            |                                                             |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>Balto City</b>                                                                                                                     |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                |                            | 13e. STREET ADDRESS<br><b>1323 N. Calhoun Street, 21217</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                             |                                                       |                                                                                                                                                                                                                                                                                                                                                |                            |                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br><b>220-18-4875</b>                                                                                                              |                                                       | 17. INFORMANT<br>ADDRESS<br><b>Charles Harrison, 5508 Stonington Avenue 21207</b>                                                                                                                                                                                                                                                              |                            |                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Respiratory insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>sepsis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>20 minutes</b> |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                       |                                                                                                                                                                                                                                                                                                                                                |                            |                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>2 and 3rd degree burns</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                       |                                                                                                                                                                                                                                                                                                                                                |                            |                                                             |  |
| 19a. DATE OF OPERATION<br><b>4/6/86</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>2 + 3rd degree burns</b>                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                     |                            |                                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2/16/86</b>                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>Found 2 cigarette in bed - fire</b>                                    |                                                       |                                                                                                                                                                                                                                                                                                                                                |                            |                                                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>at home</b>                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>5517 Baltimore Baltimore MD</b>                                                                     |                                                       | 21g. I certify that (I) (this hospital) attended the deceased from <b>April 7, 1986</b> to <b>April 16, 1986</b> , that (I) (we) last saw the deceased alive on <b>April 16, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |                            |                                                             |  |
| 22a. SIGNATURE<br><b>David Joe Briones</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                      |  | DEGREE<br><b>MD</b>                                                                                                                                         |                                                       | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                                     |                            | 22c. DATE SIGNED<br><b>4/16/86</b>                          |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID JOE BRIONES</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                      |  | 22d. ADDRESS<br><b>1-ORVILLE CT 3A Pikesville MD 21208</b>                                                                                                  |                                                       |                                                                                                                                                                                                                                                                                                                                                |                            |                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>4/17/86</b>                                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial Pk</b>                                                                                           |                                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville, Baltimore Co., Md</b>                                                                                                                                                                                                                                                            |                            |                                                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JAMES N. KOTSIS F.H.,</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                      |  | ADDRESS<br><b>6411 Windsor Mill Rd.</b>                                                                                                                     |                                                       | 25a. DATE REC'D. BY REGISTRAR (DATE, REGISTER, AND SIGNATURE)<br><b>APR 24 1986</b>                                                                                                                                                                                                                                                            |                            |                                                             |  |

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00-04864

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10620

REG. NO.

|                                                                                         |  |                                                                                                                                     |                                                       |                                                                                                                                                             |                              |                                                                                    |  |                                           |                                                               |                  |  |
|-----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------------|--|-------------------------------------------|---------------------------------------------------------------|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Margaret Rose Denver</i> |  |                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>4-23-86</i> |                                                                                                                                                             | 2b. HOUR<br><i>7:34 P.M.</i> |                                                                                    |  |                                           |                                                               |                  |  |
| 3. SEX<br><i>Female</i>                                                                 |  | 4. RACE<br><i>White</i>                                                                                                             |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 10 10</i>                                                                                                        |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>76</i>                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |                                                               | IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                       |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                  |  |                                           |                                                               |                  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Church Hospital</i> |                                                       |                                                                                                                                                             |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i> |  |                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>C&amp;P Telephone</i> |                  |  |

|                                                                                                                          |  |                                                                               |                      |                                                                                |                                       |  |                                                                                                 |  |                                                                       |  |  |
|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------|---------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i> |  |                                                                               | 13b. COUNTY<br>----- |                                                                                | 13c. CITY OR TOWN<br><i>Baltimore</i> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><i>512 South Streeper St. 21224</i> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William L. Denver</i>                                                       |  |                                                                               |                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Veronica Wonger</i>        |                                       |  |                                                                                                 |  |                                                                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>212-05-1085</i> |                      | 17. INFORMANT<br>ADDRESS<br><i>Elizabeth Poehler 512 S. Streeper St. 21224</i> |                                       |  |                                                                                                 |  |                                                                       |  |  |

|                                                                                                                                                                                                                                                                                                                                                         |  |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia</i><br><i>8583</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Digoxin Toxicity</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|                                                                                                                                                          |  |                                                                        |  |                                                                                      |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                            |  |

22a. I certify that (I) (this hospital) attended the deceased from APRIL 23, 1986 to APRIL 23, 1986, that (I) (we) (on) saw the deceased (on) APRIL 23, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.)

|                                                                  |  |                                                                                                     |  |                                    |  |
|------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|------------------------------------|--|
| 22b. SIGNATURE<br><i>Richard J. Jones</i>                        |  | DEGREE                                                                                              |  | 22c. DATE SIGNED<br><i>4/23/86</i> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Richard J. Jones</i> |  | 22e. ADDRESS<br><i>100 N. BROADWAY BALTIMORE MD. X22</i><br><i>Church Hosp. Baltimore, MD 21213</i> |  |                                    |  |

|                                                                         |  |                             |  |                                                                                         |  |                                                  |  |
|-------------------------------------------------------------------------|--|-----------------------------|--|-----------------------------------------------------------------------------------------|--|--------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>              |  | 23b. DATE<br><i>4-26-86</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Oak Lawn Cemetery Eastwood, Balto. Co. Md.</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles S. Zeiler &amp; Son Inc.</i> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 25 1986</i>                                     |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-03691

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10621

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                               |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George Milton Depfer                                                                                                                                                                                                                                                                                                              |                                                                                                                                 |                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 14, 1986                                                                                                      |                                                                               | 2b. HOUR<br>7:14A.M.                                                                                                       |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                            | 4 RACE<br>White                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 2 1920                         |                                                                                                                                                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |                                                                        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Key Medical Center |                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Lathe Operator                                                                         |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>C.M. Kemp                                                                             |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                   | 13b. COUNTY<br>Baltimore                                                                                                        | 13c. CITY OR TOWN<br>Dundalk                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                            | 13e. STREET ADDRESS / ZIP CODE<br>3908 Glenhurst Road 21222                   |                                                                                                                            |
| FATHER'S NAME<br>FIRST MIDDLE LAST<br>George M. Depfer                                                                                                                                                                                                                                                                                                                   |                                                                                                                                 | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary G. Riley          |                                                                                                                                                            |                                                                               |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II                                                                                                                                                                                                                                                            |                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br>218-03-5563                                |                                                                                                                                                            | 17. INFORMANT<br>Helen L. Depfer Same as 13e                                  |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma lung</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                     |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                         |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                               |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April 19 86</i> to <i>April 19 86</i> that (I) <del>(we)</del> lost<br>saw the deceased alive on <i>April 19 86</i> and that in (my) <del>(our)</del> best opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>(we)</del> did not view the body after death. |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                               |                                                                                                                            |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                 | DEGREE                                                                 |                                                                                                                                                            | 22c. DATE SIGNED                                                              |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MYO TITAM                                                                                                                                                                                                                                                                                                                       |                                                                                                                                 | 22e. ADDRESS                                                           |                                                                                                                                                            |                                                                               |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                |                                                                                                                                 | 23b. DATE<br>4/15/1986                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview                                                                                                             |                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                           |
| 24 FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, Maryland 21222                                                                                                                                                                                                                                                                                  |                                                                                                                                 |                                                                        | 25a. DATE REC'D. BY REGISTRAR<br>APR 15 1986                                                                                                               |                                                                               |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                 |                                                                        | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                           |                                                                               |                                                                                                                            |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

10000-00



10000-00

00-03785

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10622

FOR  
1- STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  |                                                                                                                                                           |  |                                                                                                                                    |  |                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>JOHN<sup>ST</sup> ROBERT DICKSON, SR. Ret. Lt. Col. Army</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>4 11 86</b>                                                                                                           |  |                                                                                                                                    |  | 2b. HOUR <b>5:30 PM</b>                                            |  |
| 3. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE <b>WHITE</b>                                                                                                                   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>3 24 1917</b>                                                                                                          |  | 6. AGE (IN YEARS) (LAST BIRTHDAY) <b>69</b> YRS.                                                                                   |  | 7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>                          |  |
| 8. BIRTHPLACE (STATE OR FOREIGN) <b>PA Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                              |  | 9. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>                                                                                             |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>                                                                    |  |                                                                    |  |
| 12. CITY OR TOWN OF DEATH <b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WYMAN PARK HEALTH SYSTEM</b> |  |                                                                                                                                                           |  | 14. USUAL OCCUPATION (TYPE OF WORKING FOR MOST OF WORKING LIFE) <b>Ret. Lt. Col.</b>                                               |  | 15. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>                  |  |
| 16a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALT</b> 13c. CITY OR TOWN <b>Cockeysville</b>                                                                                                                                                                                                                                      |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                           |  | 13e. STREET ADDRESS / ZIP CODE <b>10215 Greenside Drive 41203</b>                                                                                         |  |                                                                                                                                    |  |                                                                    |  |
| 17. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>M</b> LAST <b>DICKSON</b>                                                                                                                                                                                                                                                                                                                                              |  | 18. MOTHER'S MAIDEN NAME FIRST <b>Eva</b> MIDDLE <b>ATLEE</b> LAST <b>ATLEE</b>                                                        |  | 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>                                       |  | 20. SOCIAL SECURITY NO <b>717 09 9029</b>                                                                                          |  | 21. INFORMANT ADDRESS <b>Mrs. Laura Anna Dickson, Same as #13e</b> |  |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Deep venous Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Dysseminated (Carcinomatosis)</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA of the PROSTATE.</b> |  |                                                                                                                                        |  |                                                                                                                                                           |  |                                                                                                                                    |  |                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH</b>                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  |                                                                                                                                                           |  |                                                                                                                                    |  |                                                                    |  |
| 23a. DATE OF OPERATION <b>—</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  | 24a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |  | 24b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                                    |  |
| 25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                   |  | 25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                            |  | 25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                             |  |                                                                                                                                    |  |                                                                    |  |
| 26a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                             |  | 26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 26c. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                            |  |                                                                                                                                    |  |                                                                    |  |
| 27. I certify that (this hospital) attended the deceased from <b>3/12/86</b> , 19 <b>86</b> , to <b>4/11</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>4/11</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                     |  |                                                                                                                                        |  |                                                                                                                                                           |  |                                                                                                                                    |  |                                                                    |  |
| 28. SIGNATURE <b>P. Patel</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 29. DEGREE <b>M.B.Ch.B.</b>                                                                                                            |  | 30. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>            |  | 31. DATE SIGNED <b>4/11/86</b>                                                                                                     |  |                                                                    |  |
| 32. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PRAKASH. C. PATEL</b>                                                                                                                                                                                                                                                                                                                                                        |  | 33. ADDRESS <b>WYMAN PARK DRIVE, BALTO, MD 21218</b>                                                                                   |  |                                                                                                                                                           |  |                                                                                                                                    |  |                                                                    |  |
| 34a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                           |  | 34b. DATE <b>4-12-86</b>                                                                                                               |  | 34c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>                                                                                              |  | 34d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>                                                                 |  |                                                                    |  |
| 35. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                      |  | 35b. ADDRESS <b>1050 York Rd. Towson, Md. 21204</b>                                                                                    |  | 36. DATE REC'D. BY REGISTRAR <b>APR 16 1986</b>                                                                                                           |  | 37. REGISTRAR'S SIGNATURE <b>Jana Davidson</b>                                                                                     |  |                                                                    |  |

14. 5-10-11 2. 10-11-11 3. 11-12-11 4. 12-1-12 5. 1-2-12 6. 2-3-12 7. 3-4-12 8. 4-5-12 9. 5-6-12 10. 6-7-12 11. 7-8-12 12. 8-9-12 13. 9-10-12 14. 10-11-12 15. 11-12-12 16. 12-1-13 17. 1-2-13 18. 2-3-13 19. 3-4-13 20. 4-5-13 21. 5-6-13 22. 6-7-13 23. 7-8-13 24. 8-9-13 25. 9-10-13 26. 10-11-13 27. 11-12-13 28. 12-1-14 29. 1-2-14 30. 2-3-14 31. 3-4-14 32. 4-5-14 33. 5-6-14 34. 6-7-14 35. 7-8-14 36. 8-9-14 37. 9-10-14 38. 10-11-14 39. 11-12-14 40. 12-1-15 41. 1-2-15 42. 2-3-15 43. 3-4-15 44. 4-5-15 45. 5-6-15 46. 6-7-15 47. 7-8-15 48. 8-9-15 49. 9-10-15 50. 10-11-15 51. 11-12-15 52. 12-1-16 53. 1-2-16 54. 2-3-16 55. 3-4-16 56. 4-5-16 57. 5-6-16 58. 6-7-16 59. 7-8-16 60. 8-9-16 61. 9-10-16 62. 10-11-16 63. 11-12-16 64. 12-1-17 65. 1-2-17 66. 2-3-17 67. 3-4-17 68. 4-5-17 69. 5-6-17 70. 6-7-17 71. 7-8-17 72. 8-9-17 73. 9-10-17 74. 10-11-17 75. 11-12-17 76. 12-1-18 77. 1-2-18 78. 2-3-18 79. 3-4-18 80. 4-5-18 81. 5-6-18 82. 6-7-18 83. 7-8-18 84. 8-9-18 85. 9-10-18 86. 10-11-18 87. 11-12-18 88. 12-1-19 89. 1-2-19 90. 2-3-19 91. 3-4-19 92. 4-5-19 93. 5-6-19 94. 6-7-19 95. 7-8-19 96. 8-9-19 97. 9-10-19 98. 10-11-19 99. 11-12-19 100. 12-1-20

00-03074

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 6 2 3  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |                                                             |                                                                                                                                                          |                           |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES DIETZ</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 1, 1986</b> |                                                                                                                                                          | 2b. HOUR<br><b>12:20P</b> |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>White</b>                                                                                                          |                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 28 21</b>                                                                                                     |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                                                                          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                     |                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hosp.</b> |                                                             |                                                                                                                                                          |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY                                                                                                                      |                                                             | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                       |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                    |                                                             |                                                                                                                                                          |                           |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>218-14-2844</b>                                                                                   |                                                             | 17. INFORMANT ADDRESS                                                                                                                                    |                           |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>(BOWEL GANGRENE)</b> |  |                                                                                                                                  |                                                             |                                                                                                                                                          |                           |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>GANGRENE LEFT TOES</b><br><b>RENAL FAILURE JAUNDICE BLEEDING DIAPHRAGM THROMBOCYTOPENIA</b>                                                                                                                                                   |  |                                                                                                                                  |                                                             |                                                                                                                                                          |                           |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>3/20/3/21/ 4/1 3/15/86</b>                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>peripheral VASCULAR DISEASE</b>                                           |                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                     |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY OCCURRED<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                       |                                                             | 21c. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                           |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |                           |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>MARCH 10 1986</b> , to <b>APRIL 1 1986</b> , that (I) (we) (we) saw the deceased prior to <b>APRIL 1 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |                                                                                                                                  |                                                             |                                                                                                                                                          |                           |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>George Thomas M.D.</i>                                                                                                                                                                                                                                                                                                                                        |  | DEGREE                                                                                                                           |                                                             | 22c. DATE SIGNED<br><b>4/1/86</b>                                                                                                                        |                           |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE THOMAS M.D.</b>                                                                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTIMORE, MD. 21231</b>                                      |                                                             |                                                                                                                                                          |                           |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>4-4-86</b>                                                                                                       |                                                             | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Anatomy Board Balto., Md.</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 10 1986</b>                                                                                                      |                           | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                                                                         |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card and pages 3, 4, and 5. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10624  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                    |                                                                                                                                                  |                                                                                      |                                                                                                 |                                                                                                                            |                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George Diggs                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 25 86 |                                                                                                                                                  |                                                                                      | 2b. HOUR<br>12 P M                                                                              |                                                                                                                            |                                                                                        |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>B                                                                                                                              |                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 15 02                                                                                                    |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84                                                           |                                                                                                                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                           |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                    |                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD.                                     |                                                                                                                            |                                                                                        |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER PENN. MEDICAL CENTER |                                                    |                                                                                                                                                  |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br>BALTO                                                                                                                      |                                                    | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                   |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>27 SOLAR CIRCLE 21234                                |  |
| 14. FATHER'S NAME<br>UNKNOWN                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>UNKNOWN                |                                                                                                                                                  |                                                                                      |                                                                                                 |                                                                                                                            |                                                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>UNKNOWN                                                                                                       |                                                    | 17. INFORMANT ADDRESS<br>HELEN DODSON 27 SOLAR CIRCLE                                                                                            |                                                                                      |                                                                                                 |                                                                                                                            |                                                                                        |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Severe COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                    |  |                                                                                                                                           |                                                    |                                                                                                                                                  |                                                                                      |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 minutes</u><br><u>many years</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                    |                                                                                                                                                  |                                                                                      |                                                                                                 |                                                                                                                            |                                                                                        |  |
| 19a. DATE OF OPERATION<br>n/a                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                    |                                                                                                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19                                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                |                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                    |                                                                                      |                                                                                                 |                                                                                                                            |                                                                                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |                                                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 28</u> , 19 <u>86</u> , to <u>April 25</u> , 19 <u>86</u> , that (I) (we) <input checked="" type="checkbox"/> lost<br>saw the deceased alive on <u>April 25</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) <input checked="" type="checkbox"/> did not see the body after death. <u>86</u> |  |                                                                                                                                           |                                                    |                                                                                                                                                  |                                                                                      |                                                                                                 |                                                                                                                            |                                                                                        |  |
| 22b. SIGNATURE<br>Richard F. Tyson, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |                                                    |                                                                                                                                                  |                                                                                      | 22c. DATE SIGNED<br>25 April 86                                                                 |                                                                                                                            |                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard F. Tyson, M.D.                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                    |                                                                                                                                                  |                                                                                      | 22e. ADDRESS<br>936 W. North Ave., Balto., MD. 21217-3992                                       |                                                                                                                            |                                                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br>5-2-86                                                                                                                       |                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL                                                                                                 |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ANNE ARUNDEL MD.                                  |                                                                                                                            |                                                                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>WM.C.MARCH F/H INC. 1101 E. NORTH AVE.                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |                                                    |                                                                                                                                                  |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br>MAY 1 1986                                                     |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE                                                             |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 4 completed.

10/10/10

10/10/10



10/10/10



10-056818

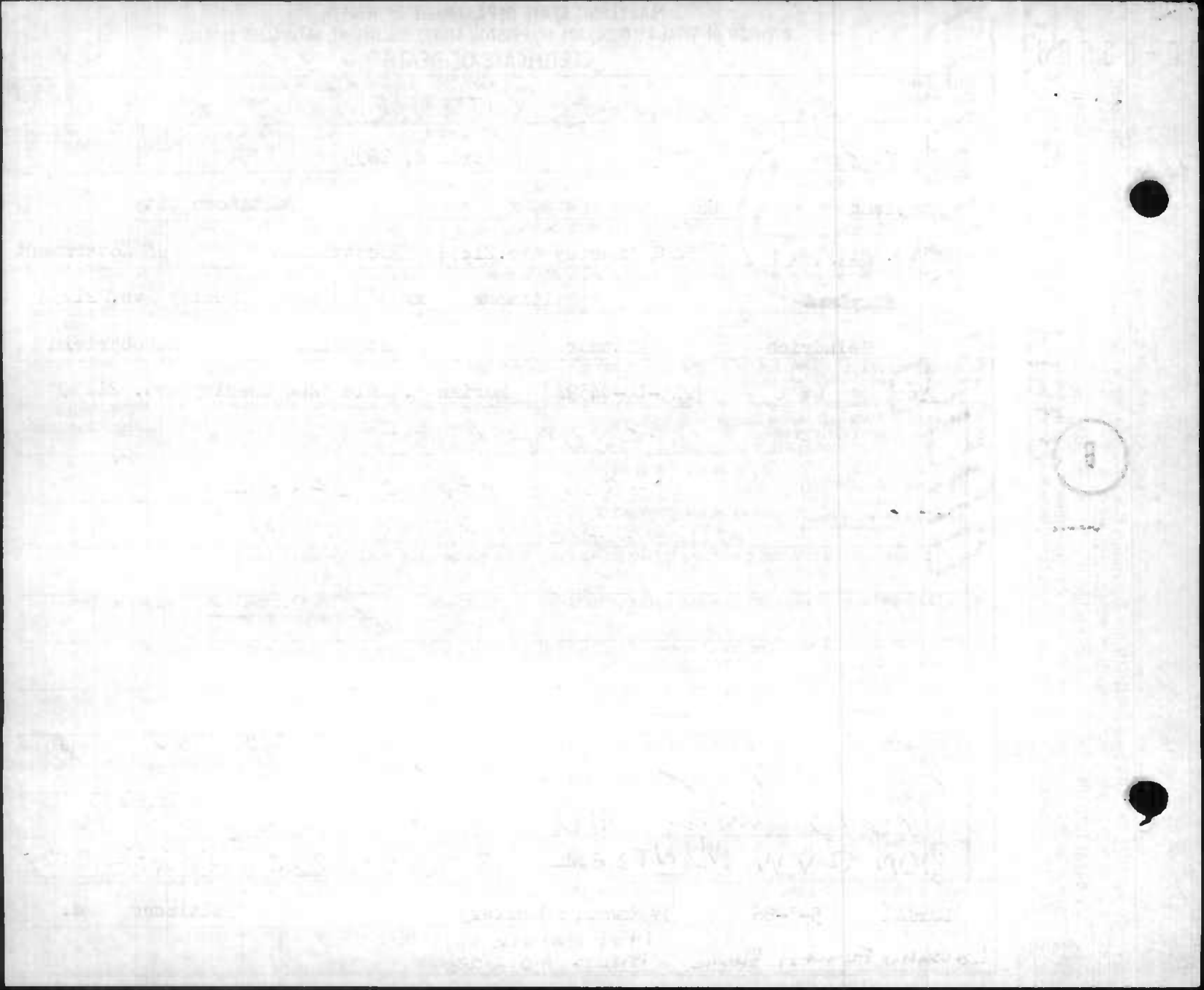
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

86 10625

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                |                                                                                                                                                             |                                                                                                               |                                                                                      |                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>JOAN FREDERICK DITTMAR</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>30</b> Year <b>86</b>                                              |                                                                                      | 2b. HOUR<br><b>1:07</b> M                                  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br><b>CAU</b>                                                                                          | 5. DATE OF BIRTH<br><b>April 4, 1895</b>                                                                                                                    |                                                                                                               | 6. AGE (In years last birthday)<br><b>91</b> YRS.                                    | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore City</b> Md.                                                               |                                                                                      |                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. City</b>                                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>3404 Chesley Ave. 21234</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Electrician</b> |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US Government</b>  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                              | 13b. COUNTY<br><b>Baltimore</b>                                                                                | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br><b>YES</b> NO <input type="checkbox"/>                                            | 13e. STREET AND NUMBER<br><b>3404 Chesley Ave. 21234</b>                             |                                                            |
| 14. FATHER'S NAME First Middle Last<br><b>Heindrich Dittmar</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Katherine Schoberlein</b>                                                                                  |                                                                                                               |                                                                                      |                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>Yes WW I</b>                                                                                                                                                                                                                                                                                      |                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>215-10-0439A</b>                                                                                                             | 17. INFORMANT Address<br><b>Marian R. Adle 3404 Chesley Ave. 21234</b>                                        |                                                                                      |                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASCVD - CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC PEPTIC ULCER</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>DISEASE &amp; OBSTRUCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                |                                                                                                                                                             |                                                                                                               |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                           |                                                                                                                |                                                                                                                                                             |                                                                                                               |                                                                                      |                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                            |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                          |                                                                                                                |                                                                                                                                                             |                                                                                                               |                                                                                      |                                                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/><br>(If either, notify medical examiner)                                                                                                                                                                                                                                         |                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                                                                  |                                                                                                               | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |                                                            |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                |                                                                                                                | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                                                |                                                                                                               | 21f. LOCATION Street or R.D. No. City or Town County State                           |                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>4/30</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                        |                                                                                                                |                                                                                                                                                             |                                                                                                               |                                                                                      |                                                            |
| 22b. SIGNATURE<br><b>Donald W. Mintzer M.D.</b>                                                                                                                                                                                                                                                                                                                                               |                                                                                                                | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |                                                                                                               | 22c. DATE SIGNED<br><b>4/30/86</b>                                                   |                                                            |
| 22d. PHYSICIAN'S NAME (Type or print)<br><b>Donald W. MINTZER</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                | 22e. ADDRESS<br><b>3009 EVERGREEN AVE</b>                                                                                                                   |                                                                                                               |                                                                                      |                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                    | 23b. DATE<br><b>5-3-86</b>                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                                                                                              |                                                                                                               | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                |                                                            |
| 24. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home</b>                                                                                                                                                                                                                                                                                                                                           |                                                                                                                | 25a. REC'D BY REGISTRAR<br><b>1401 Bel Air Rd. BALTO. MD 21201</b>                                                                                          |                                                                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>05 1986</b>                                         |                                                            |



00-04198

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-9, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR Film G615 item 218

1- STATE REGISTRAR 5/27/86 rja

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10626

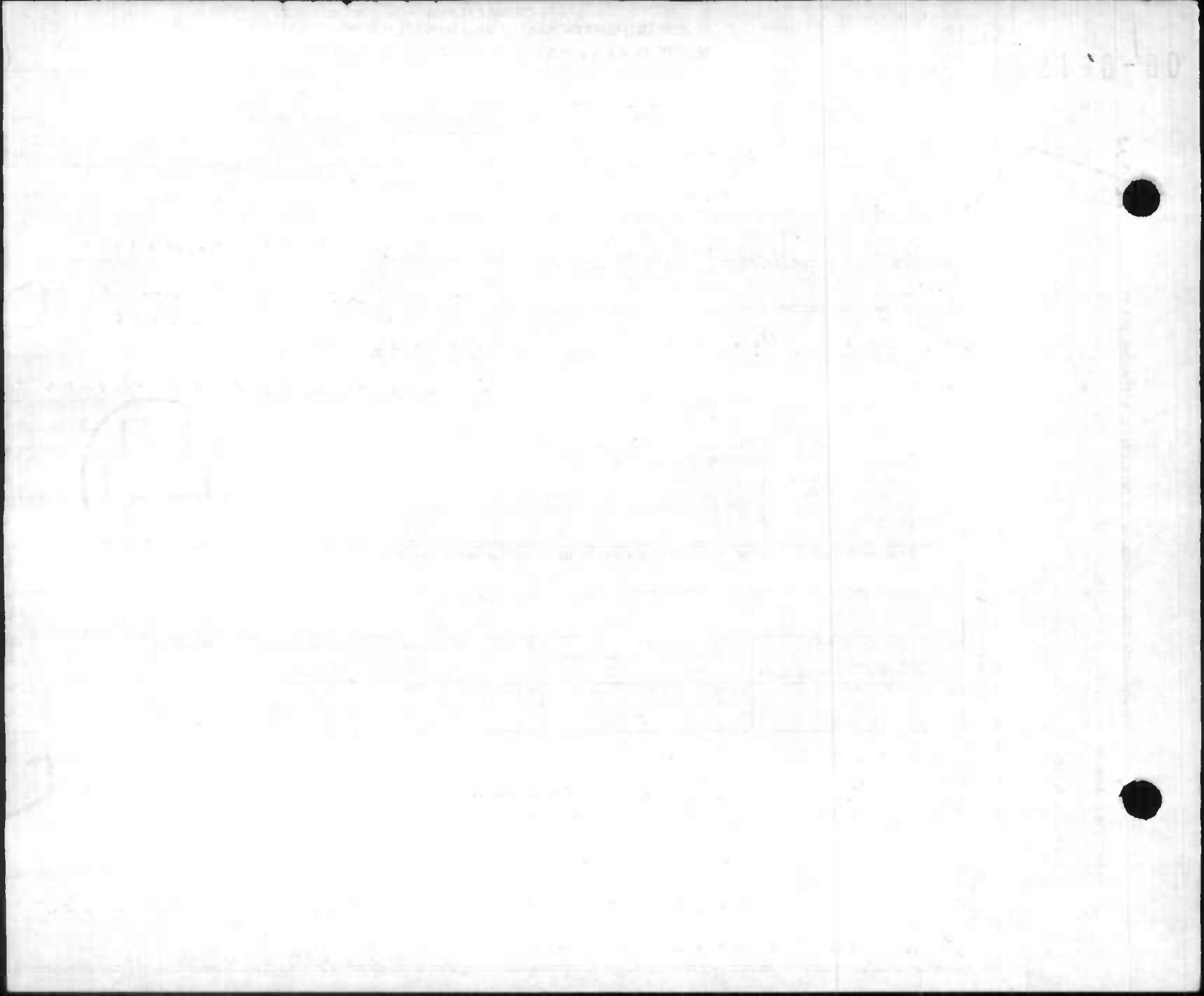
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                  |                                                                                                    |                                                                                                                                                             |                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Stanley KEVIN Dorsey                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>4 20 86 |                                                                                                                                                             | 2b. HOUR<br>M<br>12:00<br>A.M.                                                      |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br>D | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 26 67                                                                                                    | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>18 YRS.                                                      | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    | IF UNDER 24 HRS.<br>HOURS MIN.                                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore MD                                                                                                                                                                                                                                                                                                                                                                                         |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                              |                                                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                     |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                            |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Playground-Lafayette & Payson Sts. |                                                                                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CARNIVAL WORKER                                                                            |                                                                                     |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                  |              | 13b. COUNTY                                                                                                                                      | 13c. CITY OR TOWN                                                                                  | 13d. STREET ADDRESS<br>2715 W. Moshon St                                                                                                                    |                                                                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Stanley Dorsey                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Brenda Nelson                                     |                                                                                                                                                             |                                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                       |              | 16b. SOCIAL SECURITY NO.                                                                                                                         |                                                                                                    | 17. INFORMANT ADDRESS<br>Brenda Dorsey 2715 W. Moshon St                                                                                                    |                                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gunshot wound of head<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)                                                                                                                                             |              |                                                                                                                                                  |                                                                                                    |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                  |                                                                                                    |                                                                                                                                                             |                                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                            |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                |                                                                                                    |                                                                                                                                                             | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |              | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>11:30 P.M. 4/19/ 1986                                                                              |                                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>Subject shot.                                                              |                                                                                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                              |              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>playground                                                                        |                                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Lafayette & Payson Sts. Balt. City MD                                                                  |                                                                                     |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |              |                                                                                                                                                  |                                                                                                    |                                                                                                                                                             |                                                                                     |
| ACTUAL SIGNATURE<br>Dennis F. Smyth                                                                                                                                                                                                                                                                                                                                                                                                               |              | TITLE (SPECIFY)<br>M.D. Assistant                                                                                                                |                                                                                                    | DATE SIGNED<br>4-20-86                                                                                                                                      |                                                                                     |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                       |              | ADDRESS<br>111 Penn St., Balt., MD 21201                                                                                                         |                                                                                                    |                                                                                                                                                             |                                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                            |              | 23b. DATE<br>4/24/86                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill                                                   |                                                                                                                                                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD 21225                    |
| 24. FUNERAL DIRECTOR<br>M. J. Hall                                                                                                                                                                                                                                                                                                                                                                                                                |              | ADDRESS<br>218 N. 9th St.                                                                                                                        |                                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br>APR 21 1986                                                                                                                |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              | 25b. REGISTRAR'S SIGNATURE<br>John Davidson                                                                                                      |                                                                                                    |                                                                                                                                                             |                                                                                     |

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

21-50-00



00-03671

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610627

|                                                                                                                                                                                        |  |                                                         |  |                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                 |  | 2a. DATE OF DEATH                                       |  | 2b. HOUR                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                       |  | 2a. DATE OF DEATH                                       |  | 2b. HOUR                                                            |  |
| WILBERT                                                                                                                                                                                |  | 4 10 86                                                 |  | 120 P.M.                                                            |  |
| 3. SEX                                                                                                                                                                                 |  | 5. DATE OF BIRTH                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male                                                                                                                                                                                   |  | 1 27 08                                                 |  | 78 YRS.                                                             |  |
| 4. RACE                                                                                                                                                                                |  | 7. CITIZEN OF WHAT COUNTRY?                             |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Black                                                                                                                                                                                  |  | U.S.                                                    |  | Baltimore, City                                                     |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION                                               |  |
| Balt.                                                                                                                                                                                  |  | S.B.G.H.                                                |  | Truck Delivery                                                      |  |
| 13a. STATE                                                                                                                                                                             |  | 13b. CITY OR TOWN                                       |  | 13c. STREET ADDRESS / ZIP CODE                                      |  |
| MD                                                                                                                                                                                     |  | Balt.                                                   |  | 2121 Windsor Garden Lane Baltimore, Md. 21207                       |  |
| 14. FATHER'S NAME                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                        |  |
| Clarence                                                                                                                                                                               |  | Irene                                                   |  | no                                                                  |  |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                               |  | 17. INFORMANT                                           |  | 18. CAUSE OF DEATH                                                  |  |
| 217-07-4550                                                                                                                                                                            |  | Irene Dorsey                                            |  | Cardiorespiratory arrest                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  | 20a. AUTOPSY?                                                       |  |
|                                                                                                                                                                                        |  |                                                         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING                                                                                                                                                           |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED                                            |  |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                       |  | HOUR A.M. MONTH DAY YEAR                                |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                   |  | P.M. 19                                                 |  |                                                                     |  |
| 21d. INJURY OCCURRED                                                                                                                                                                   |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION                                                       |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                      |  | (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)           |  | CITY OR TOWN COUNTY STATE                                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost                                                                                        |  |                                                         |  |                                                                     |  |
| saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                         |  |                                                                     |  |
| 22b. SIGNATURE                                                                                                                                                                         |  |                                                         |  | 22c. DATE SIGNED                                                    |  |
| MICHAEL KAZAK MD                                                                                                                                                                       |  |                                                         |  | 4-10-86                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                  |  |                                                         |  | 22e. ADDRESS                                                        |  |
| MICHAEL KAZAK MD                                                                                                                                                                       |  |                                                         |  |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                              |  | 23b. DATE                                               |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |
| Burial                                                                                                                                                                                 |  | 4/14/1986                                               |  | Mt. Auburn Cemetery                                                 |  |
| 23d. LOCATION                                                                                                                                                                          |  | 23e. DATE REC'D. BY REGISTRAR                           |  | 23f. REGISTRAR'S SIGNATURE                                          |  |
| CITY OR TOWN COUNTY STATE                                                                                                                                                              |  | APR 15 1986                                             |  | Jenna Gordon-Randall                                                |  |
| Baltimore Md.                                                                                                                                                                          |  |                                                         |  |                                                                     |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                   |  |                                                         |  |                                                                     |  |
| Nutter & Sons Funeral Home, Inc. 2501 Gwynns Falls Pkwy Baltimore, Md. 21216                                                                                                           |  |                                                         |  |                                                                     |  |

1881-1882

1881-1882

1881-1882

00-02423

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

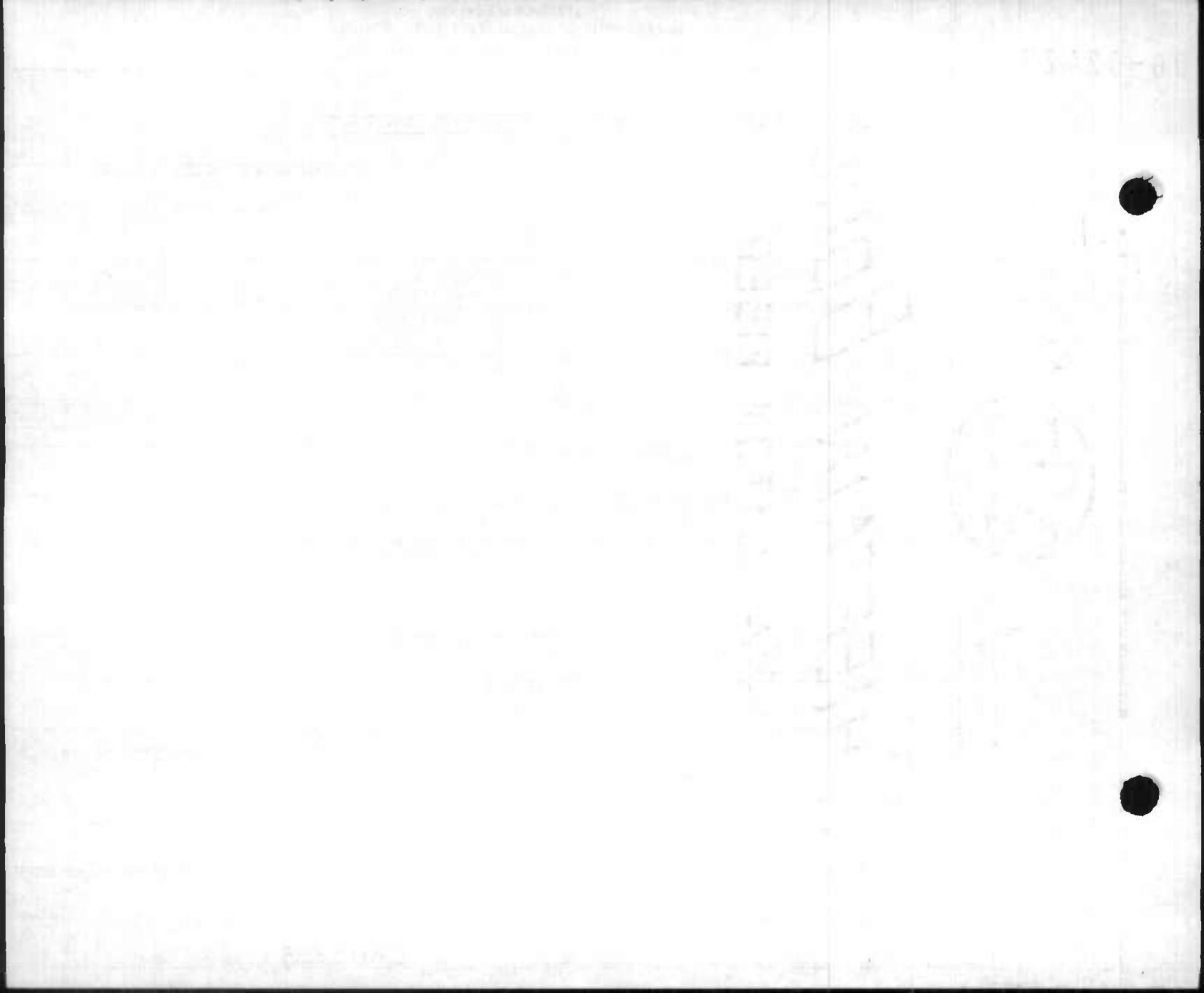
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10628

|                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                                                          |                                                                     |                                                                               |                                   |                            |                         |                                                |       |          |      |          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------|----------------------------|-------------------------|------------------------------------------------|-------|----------|------|----------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | DECEASED NAME (TYPE OR PRINT)                                                                                                                            |                                                                     | FIRST                                                                         | MIDDLE                            | LAST                       | 2a. DATE KNOWN OF DEATH | <input checked="" type="checkbox"/> ESTI MATED | MONTH | DAY      | YEAR | 2b. HOUR |
|                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         | Delman (Delmon)                                                                                                                                          |                                                                     |                                                                               |                                   | Doss                       |                         | <input type="checkbox"/>                       | 4     | 1        | 1986 | M        |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE                                                                                                 | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS)                                                   | IF UNDER 1 YR.                                                                | IF UNDER 24 HRS.                  | 7c. DATE PRONOUNCED DEAD   | MONTH                   | DAY                                            | YEAR  | 2d. HOUR |      |          |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                          | Black                                                                                                   | 12 4 27                                                                                                                                                  | 58                                                                  | MONTHS                                                                        | DAYS                              | 4                          | 1                       | 1986                                           |       | 7:40     | A M  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?                                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH                                          |                                   |                            |                         |                                                |       |          |      |          |
| Ala.                                                                                                                                                                                                                                                                                                                                                                                                                                          | USA                                                                                                     |                                                                                                                                                          |                                                                     | Baltimore City,                                                               |                                   | MD                         |                         |                                                |       |          |      |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY |                            |                         |                                                |       |          |      |          |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                     | 815 George St.                                                                                          |                                                                                                                                                          | N/A                                                                 |                                                                               |                                   |                            |                         |                                                |       |          |      |          |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                    | 13b. COUNTY                                                                                             | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                                                           |                                   |                            |                         |                                                |       |          |      |          |
| MD                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         | Baltimore                                                                                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 815 George St.                                                                | Apt. 11H 21201                    |                            |                         |                                                |       |          |      |          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                                     |                                                                               |                                   |                            |                         |                                                |       |          |      |          |
| Steve                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         | Addie Mae Seroyer                                                                                                                                        |                                                                     |                                                                               |                                   |                            |                         |                                                |       |          |      |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                                     | 17. INFORMANT ADDRESS                                                         |                                   |                            |                         |                                                |       |          |      |          |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         | N/A                                                                                                                                                      |                                                                     | Steve Doss 3448 Reisterstown Road                                             |                                   |                            |                         |                                                |       |          |      |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |                                                                                                         |                                                                                                                                                          |                                                                     |                                                                               |                                   |                            |                         |                                                |       |          |      |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I                                                                                                                                                                                                                                                                                                                |                                                                                                         |                                                                                                                                                          |                                                                     |                                                                               |                                   |                            |                         |                                                |       |          |      |          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |                                                                     | 20. AUTOPSY?                                                                  |                                   |                            |                         |                                                |       |          |      |          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                                                          |                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                                   |                            |                         |                                                |       |          |      |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                           |                                                                                                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                                   |                            |                         |                                                |       |          |      |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                      |                                                                                                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                              |                                                                     | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                                   |                            |                         |                                                |       |          |      |          |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                                                                                                         |                                                                                                                                                          |                                                                     |                                                                               |                                   |                            |                         |                                                |       |          |      |          |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         | TITLE (SPECIFY)                                                                                                                                          |                                                                     | DATE SIGNED                                                                   |                                   |                            |                         |                                                |       |          |      |          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         | M.D. Assistant                                                                                                                                           |                                                                     | 4/1/86                                                                        |                                   |                            |                         |                                                |       |          |      |          |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         | ADDRESS                                                                                                                                                  |                                                                     |                                                                               |                                   |                            |                         |                                                |       |          |      |          |
| Gregory R. Kauffman, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | 111 Penn St.                                                                                                                                             |                                                                     |                                                                               |                                   |                            |                         |                                                |       |          |      |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | 23b. DATE                                                                                                                                                |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY                                            |                                   | 23d. LOCATION CITY OR TOWN |                         | COUNTY STATE                                   |       |          |      |          |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | 4/5/86                                                                                                                                                   |                                                                     | Church Cemetery                                                               |                                   | Lafayette                  |                         | Ala.                                           |       |          |      |          |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | ADDRESS                                                                                                                                                  |                                                                     | 25a. DATE REC'D. BY REGISTRAR                                                 |                                   | 25b. REGISTRAR'S SIGNATURE |                         |                                                |       |          |      |          |
| Wm. C. March F/H                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         | 1101 E. North Ave.                                                                                                                                       |                                                                     | APR 3 1986                                                                    |                                   | John Swider - Gordon       |                         |                                                |       |          |      |          |

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

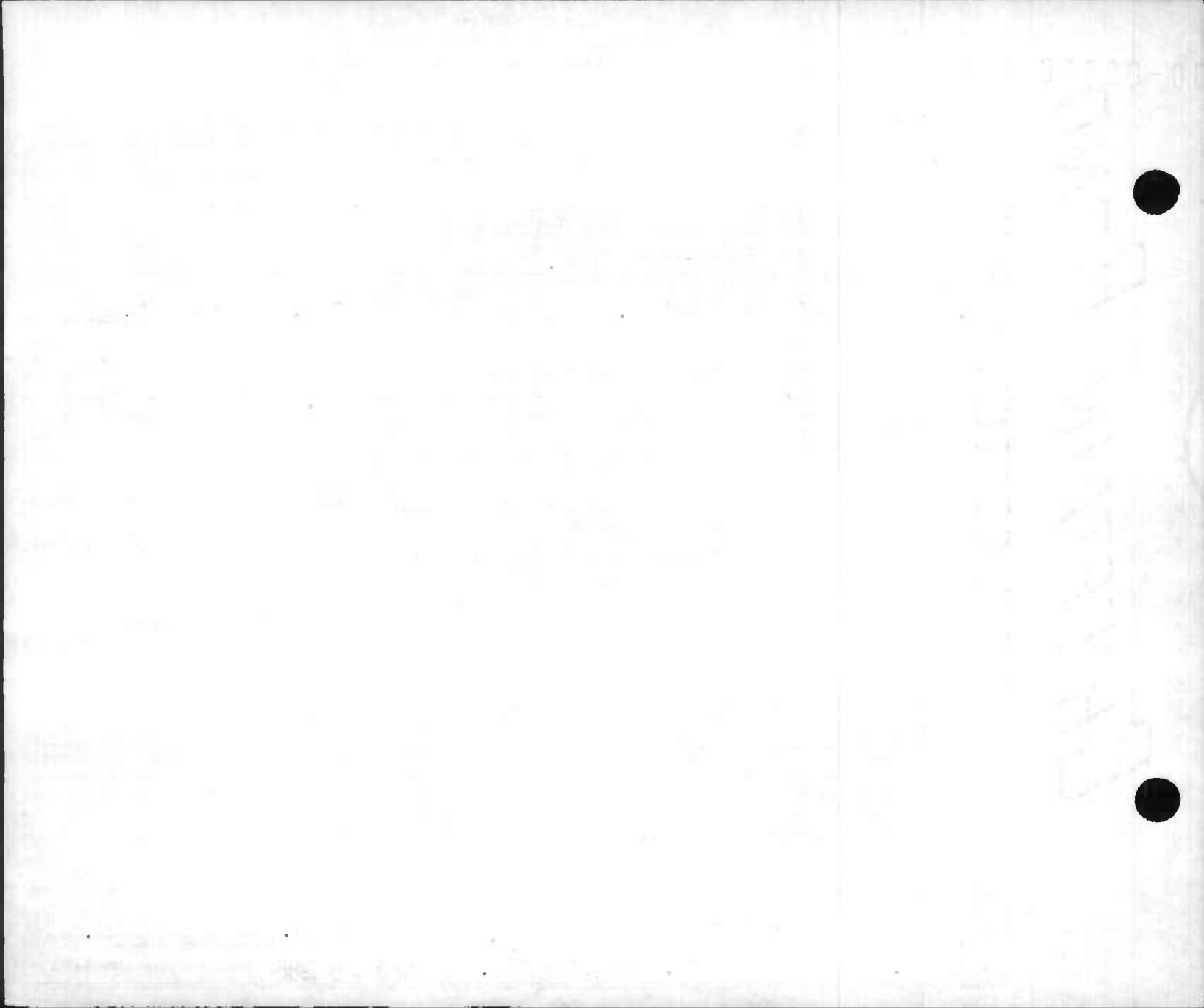
DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10629  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                               |                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                               |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <del>DOFFSON</del> Lewis M DOTSON                                                          |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4/10/86                                                                                                              |  | 2b. HOUR<br>9 <sup>22</sup> M                                                                                                 |                                                                                                                        |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>Black                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 5 1900                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS                                                                                     |                                                                                                                        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                     |                                                                                                                        |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univiersity Hosp. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |                                                                                                                        |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br>n/a                                                                                                             |  | 13c. CITY OR TOWN<br>Balto.                                                                                                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |                                                                                                                        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                  |  | 13e. STREET ADDRESS / ZIP CODE<br>2223 W. Hamburg St. 21230                                                                                                 |  |                                                                                                                               |                                                                                                                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>n/a                                                                                                |  | 17. INFORMANT ADDRESS<br>3202 Presbury St. 21216 James Jones                                                                                                |  |                                                                                                                               |                                                                                                                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>POSSIBLE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>POSSIBLE ACUTE AORTIC ANEURYSM DISSECTION</u>                               |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>20 minutes</u><br><u>perhaps 80 min</u><br><u>perhaps 60 min</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HYPERTENSION</u>                                                                                                                                                                                                                 |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                               |                                                                                                                        |
| 19a. DATE OF OPERATION<br><u>PERICARDIOTOMY</u>                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>RULE OUT pericardial tamponade</u>                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                        |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                               |                                                                                                                        |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                               |                                                                                                                        |
| 22a. I certify that (this hospital) attended the deceased from <u>4/10</u> , 19 <u>86</u> , to <u>4/10</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>4/10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                               |                                                                                                                        |
| 22b. SIGNATURE<br><u>Ludwig J. Eglseder III MD</u>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>4/10/86</u>                                                                                            |                                                                                                                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Ludwig J. Eglseder III MD</u>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                |  | 22e. ADDRESS<br><u>University of Maryland Hospital</u>                                                                                                      |  |                                                                                                                               |                                                                                                                        |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><u>4/15/86</u>                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>King Mem. Park</u>                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Balto. Md.</u>                                                               |                                                                                                                        |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Leroy O. Dyett</u>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                |  | ADDRESS<br><u>4600 Lib. Heights Ave.</u>                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><u>APR 15 1986</u>                                                                           |                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>James Davidson-Randall</u>                                                                                                 |  |                                                                                                                               |                                                                                                                        |

BP



00-05252

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10630  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |                                                       |                                                                                                                                                  |                                       |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Samuel Douglas</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-28-86</b> |                                                                                                                                                  | 2b. HOUR<br>MIN.<br><b>12:13 P.</b>   |                                                                                                                            |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>Black</b>                                                                                                                      |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 22 24</b>                                                                                             |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>61</b>                                                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                          |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General</b> |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                 |                                       | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                         |  |                                                                                                                                              | 13b. COUNTY<br><b>BALTIMORE</b>                       |                                                                                                                                                  | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRED DOUGLAS</b>                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY JACOB</b>                                                                           |                                                       | 16. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                              |                                       |                                                                                                                            |
| 17. STREET ADDRESS / ZIP CODE<br><b>120 S. CARLTON ST. 21225</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |                                                       |                                                                                                                                                  |                                       |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><b>1944-1946 216-16-4015</b>                                                                                     |                                                       | 17. INFORMANT<br><b>NANCY KANE</b> ADDRESS<br><b>120 S. CARLTON ST.</b>                                                                          |                                       |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                              |                                                       |                                                                                                                                                  |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>URAMIA, HYPONATREMIA</b>                                                                                                                                                                                          |  |                                                                                                                                              |                                                       |                                                                                                                                                  |                                       |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                   |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                   |                                       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                       |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |                                       |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/17</b> 19 <b>86</b> to <b>4/28</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/28</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.                                                        |  |                                                                                                                                              |                                                       |                                                                                                                                                  |                                       |                                                                                                                            |
| 22b. SIGNATURE<br><b>Purnushottam Mitra</b>                                                                                                                                                                                                                                                                                                           |  | DEGREE                                                                                                                                       |                                                       | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |                                       | 22c. DATE SIGNED<br><b>4-28-86</b>                                                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PURNUSHOTTAM MITRA</b>                                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS<br><b>BELG H</b>                                                                                                                |                                                       |                                                                                                                                                  |                                       |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>5-2-86</b>                                                                                                                   |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CROWNSVILLE VA.</b>                                                                                     |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CROWNSVILLE, MARYLAND</b>                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>BROWN/THOMPSON F.H.</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 30 1986</b>                                                                                              |                                       | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                           |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10631

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CLARE ELLEN DOWLING                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 5 1986                                             |                                                                                      | 2b. HOUR<br>12 <sup>30</sup> A.M.                                                                                          |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br>WHITE                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 16 58                                                                                                              |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>27 YRS.                                           | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A                         | 12b. KIND OF BUSINESS OR INDUSTRY<br>N/A                                             |                                                                                                                            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                | 13b. COUNTY                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>4220 Massachusetts Ave. 21229                      |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William H. Dowling                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Opal Price                                                                                                 |                                                                                                 |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-76-5020                                                                                      | 17. INFORMANT<br>ADDRESS<br>William Dowling, Sr. 4220 Massachusetts Ave. 21229                  |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>severe metabolic acidosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>diabetes</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                  |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                              |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 4, 1986</u> to <u>April 5, 1986</u> , that (I) (we) lost <u>April 5, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                  |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><u>Robert F. Commiato</u>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                                 | 22c. DATE SIGNED<br><u>April 5, 1986</u>                                             |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Robert F. Commiato</u>                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         | 22e. ADDRESS<br><u>FSKMC Eastern Ave. Baltimore, MD</u>                                                                                                     |                                                                                                 |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                         | 23b. DATE<br>4/8/86                                                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park                                     |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland                                                     |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         | ADDRESS<br>4107 Wilkens Ave.                                                                                                                                |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>APR 11 1986                                         | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                           |

0-05505



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610632  
REG NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages one & two, to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

## MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                         |  |                                                                                                                                                                           |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BENJAMIN</b>                                                                                                                                                                                                                                                                                                                                                                      |  | LAST <b>DROBIS</b>                                                                                                                                      |  | 2a. DATE OF DEATH<br>MONTH <b>4</b> / DAY <b>5</b> / YEAR <b>86</b>                                                                                                       |  | 2b. HOUR <b>11 P.M.</b>                                                                                                    |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>White</b>                                                                                                                                 |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> / DAY <b>28</b> / YEAR <b>04</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH CHARLES GEN'L HOSP. MD. 21208</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>VENDOR</b>                                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>                                                                         |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>Maryland</b> COUNTY <b>BALTO</b>                                                                                                                                                                                                                                                                                |  | 13c. CITY OR TOWN<br><b>OWINGS MILLS</b>                                                                                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 13e. STREET ADDRESS / ZIP CODE<br><b>APT B21117<br/>14 BITTER ROOT CT-OWINGS, MD</b>                                       |  |
| 14. FATHER'S NAME<br>FIRST <b>ABRAHAM</b> MIDDLE <b>DROBIS</b> LAST <b>PARIS</b>                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ROSE</b> MIDDLE <b>PARIS</b> LAST <b>PARIS</b>                                                                     |  |                                                                                                                                                                           |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b>                                                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>053/20/3890</b>                                                                                                          |  | 17. INFORMANT ADDRESS<br><b>LOUIS DROBIS-5608 BLAND AVE 21215</b>                                                                                                         |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>COPD &amp; Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intracerebral infarct (CVA).</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGESTIVE HEART FAILURE</b> |  |                                                                                                                                                         |  |                                                                                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>PLEURAL EFFUSION, PNEUMONIA</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                                         |  |                                                                                                                                                                           |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                         |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/19 19 86</b> to <b>4/5 19 86</b> that (we) last saw the deceased alive on <b>4/5 19 86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                |  |                                                                                                                                                         |  |                                                                                                                                                                           |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>A.C. Chouvalit, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                         |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/5/86</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.C. CHOUVALIT, M.D.</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                         |  | 22e. ADDRESS<br><b>NORTH CHARLES GEN. HOSP.</b>                                                                                                                           |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>4-8-86</b>                                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARRISON FORBET VETERAN OWINGS MILLS</b>                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALT. MD</b>                                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>HEBREW MEMORIAL F.H.</b> ADDRESS <b>1100 REISTERSTOWN RD</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 8 1986</b>                                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                                                                         |  |





00-03994

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY POSTMORTEM IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                        |                                               |                                                                                                                                                             |                                                             |                                                                                 |                                                                   |                                                                                     |  | REG. NO. 10633                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------|--|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                        |                                               |                                                                                                                                                             |                                                             |                                                                                 |                                                                   |                                                                                     |  |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>HERBERT HOWARD DRUMWRIGHT                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                        |                                               |                                                                                                                                                             |                                                             | 2a. DATE KNOWN OF DEATH<br>ESTIMATED MONTH DAY YEAR<br>4 10 19 86               |                                                                   | 2b. HOUR<br>M<br>7:20 PM                                                            |  |                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4- 7- 1924                                                                                       | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>62 S. | 7. IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                            | 8. IF UNDER 24 HRS.<br>HOURS MIN                            | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>4 10 19 86                        |                                                                   | 7d. HOUR<br>M<br>7:20 PM                                                            |  |                                              |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                     |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                               |                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                      |                                                                   |                                                                                     |  |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital (DOA) |                                               |                                                                                                                                                             |                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Crane Operator |                                                                   | 12b. KIND OF BUSINESS<br>Dry Goods Repair A. Smith & Son                            |  |                                              |
| 13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 3000 Tioga Parkway Baltimore, Maryland 21216                                                                                                                    |                  |                                                                                                                                        |                                               |                                                                                                                                                             |                                                             |                                                                                 |                                                                   |                                                                                     |  |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ross Drummwright                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                        |                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ellie Unknown                                                                                              |                                                             |                                                                                 |                                                                   |                                                                                     |  |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) Yes                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                        |                                               | 16b. SOCIAL SECURITY NO.<br>216-16-9918                                                                                                                     |                                                             | 17. INFORMANT ADDRESS<br>Aletha Mack 3704 Mohawk Avenue Baltimore, Md. 21207    |                                                                   |                                                                                     |  |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                               |                  |                                                                                                                                        |                                               |                                                                                                                                                             |                                                             |                                                                                 |                                                                   |                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                        |                                               |                                                                                                                                                             |                                                             |                                                                                 |                                                                   |                                                                                     |  |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                        |                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |                                                             |                                                                                 |                                                                   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                              |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                        |                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                                                   |                                                                                     |  |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                        |                                               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                 |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |                                                                   |                                                                                     |  |                                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |                                                                                                                                        |                                               |                                                                                                                                                             |                                                             |                                                                                 |                                                                   |                                                                                     |  |                                              |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                        |                                               | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                                                                                          |                                                             |                                                                                 |                                                                   | DATE SIGNED 4-11-86                                                                 |  |                                              |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                        |                                               | ADDRESS 111 Penn St., Balto., MD 21201                                                                                                                      |                                                             |                                                                                 |                                                                   |                                                                                     |  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                        | 23b. DATE 4/16/1986                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Veterans |                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |                                                                                     |  |                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>NUTTER & Sons Funeral Home, Inc.<br>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                        |                                               |                                                                                                                                                             |                                                             | 25a. DATE REC'D. BY REGISTRAR APR 18 1986                                       |                                                                   | 25b. REGISTRAR'S SIGNATURE Julia Davidson                                           |  |                                              |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO. 10634

|                                                                                                                                                                                                                                                                                                                                                                                                 |                              |                                                                                                           |                                                                                                                                                             |                                                                                                                                            |                                                                  |                                                                     |                                                                |                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                             |                              | FIRST MIDDLE LAST                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH                                                                                                                          |                                                                  | MONTH DAY YEAR                                                      |                                                                | 2b. HOUR                       |  |
| ALBERT DUCKLEY                                                                                                                                                                                                                                                                                                                                                                                  |                              |                                                                                                           |                                                                                                                                                             | April 22, 1986                                                                                                                             |                                                                  |                                                                     |                                                                | 8:00 A.M.                      |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE                      | 5. DATE OF BIRTH                                                                                          |                                                                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |                                                                  | IF UNDER 1 YEAR                                                     |                                                                | IF UNDER 24 HRS.               |  |
| male                                                                                                                                                                                                                                                                                                                                                                                            | Col.                         | 6-9-06                                                                                                    |                                                                                                                                                             | 78 YRS.                                                                                                                                    |                                                                  | MONTHS DAYS                                                         |                                                                | HOURS MIN.                     |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY? |                                                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |                                                                     |                                                                |                                |  |
| Kent Co. Md.                                                                                                                                                                                                                                                                                                                                                                                    | U.S.A.                       |                                                                                                           |                                                                                                                                                             |                                                                                                                                            | Baltimore City MD                                                |                                                                     |                                                                |                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                       |                              | PROVIDENT Hospital                                                                                        |                                                                                                                                                             |                                                                                                                                            | Retired                                                          |                                                                     |                                                                |                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                    |                              | 13b. COUNTY                                                                                               |                                                                                                                                                             | 13c. CITY OR TOWN                                                                                                                          |                                                                  | 13d. INSIDE CITY LIMITS?                                            |                                                                | 13e. STREET ADDRESS / ZIP CODE |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                        |                              | Baltimore                                                                                                 |                                                                                                                                                             | Baltimore                                                                                                                                  |                                                                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                | 2637 Rayner Ave. 21216         |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                               |                              | 15. MOTHER'S MAIDEN NAME                                                                                  |                                                                                                                                                             |                                                                                                                                            |                                                                  |                                                                     |                                                                |                                |  |
| Frank Duckley                                                                                                                                                                                                                                                                                                                                                                                   |                              | Cassie Duckley                                                                                            |                                                                                                                                                             |                                                                                                                                            |                                                                  |                                                                     |                                                                |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                            |                              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                                                   |                                                                                                                                                             | 17. INFORMANT                                                                                                                              |                                                                  | ADDRESS                                                             |                                                                |                                |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                              |                              | 219-03 4253A                                                                                              |                                                                                                                                                             | Mrs. Remond Duckley                                                                                                                        |                                                                  | 2637 Rayner Ave. 21216                                              |                                                                |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>COMA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>MASSIVE INTRACRANIAL HEMORRHAGE.</u> |                              |                                                                                                           |                                                                                                                                                             |                                                                                                                                            |                                                                  |                                                                     |                                                                |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                                                |                              |                                                                                                           |                                                                                                                                                             |                                                                                                                                            |                                                                  |                                                                     |                                                                |                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                                                                                                                                                             |                                                                                                                                            | 20a. AUTOPSY?                                                    |                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                 |                              |                                                                                                           |                                                                                                                                                             |                                                                                                                                            | YES <input type="checkbox"/> NO <input type="checkbox"/>         |                                                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                         |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)                                                            |                                                                  |                                                                     |                                                                |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                  |                                                                     |                                                                |                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                 |                              |                                                                                                           |                                                                                                                                                             |                                                                                                                                            |                                                                  |                                                                     |                                                                |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 28, 1986</u> to <u>April 22, 1986</u> that (I) (we) last saw the deceased alive on <u>April 22, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                 |                              |                                                                                                           |                                                                                                                                                             |                                                                                                                                            |                                                                  |                                                                     |                                                                |                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                  |                              | DEGREE                                                                                                    |                                                                                                                                                             | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                  | 22c. DATE SIGNED                                                    |                                                                |                                |  |
| <u>C.C. ONEJEME</u>                                                                                                                                                                                                                                                                                                                                                                             |                              | MD                                                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                  | 4/22/86                                                             |                                                                |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                           |                              | 22e. ADDRESS                                                                                              |                                                                                                                                                             |                                                                                                                                            |                                                                  |                                                                     |                                                                |                                |  |
| C.C. ONEJEME                                                                                                                                                                                                                                                                                                                                                                                    |                              | PROVIDENT Hospital                                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                  |                                                                     |                                                                |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                    |                              | 23b. DATE                                                                                                 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                         |                                                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                                                                |                                |  |
| B                                                                                                                                                                                                                                                                                                                                                                                               |                              | 4/29/86                                                                                                   |                                                                                                                                                             | hmd nash                                                                                                                                   |                                                                  | Lanard Md                                                           |                                                                |                                |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                            |                              | ADDRESS                                                                                                   |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |                                                                  | 25b. REGISTRAR'S SIGNATURE                                          |                                                                |                                |  |
| <u>Joseph C. Burns</u>                                                                                                                                                                                                                                                                                                                                                                          |                              | 2222 W York                                                                                               |                                                                                                                                                             | MAY 6 1986                                                                                                                                 |                                                                  | <u>John K. ...</u>                                                  |                                                                |                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-04200

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 6 3 5  
REG. NO.

|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Anita M Duncan</b>                                                                                                                                                                                                                                        |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 18 86</b>                                                                             |  | 2b. HOUR<br>M<br><b>155 A</b>                                                                                                                                                                                                                                                                                                                                                   |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>Black</b>                                                                                                           |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 1 55</b>                                                                                                                                                                                                                                                                                                                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>30</b> YRS                                                                                                                                                                                                                                                                         |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                                                                   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>                                                                                                                                                                                                                                                                                                                                 |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                             |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>                                                                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                                                                                                                                                                                                                                                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hosp</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>UNEMPLOYED</b>                                                                                                                                                                                                                                                                                           |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                        |  | 13a. STREET ADDRESS / ZIP CODE<br><b>2958 MOSHER COURT 21216</b>                                                                  |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>COLUMBUS DUNCAN</b>                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NETA JOYNER</b>                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                               |  |
| 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219 62 3470</b>                                                                                                                                                                                                                                            |  | 17. INFORMANT<br>ADDRESS<br><b>MISS DEBORAH DUNCAN 2608 QUANTICO AVE.</b>                                                         |  | 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY DISTRESS</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYO CARDIAC INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                      |  |                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                                                                                                                                                                                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 22b. SIGNATURE<br><b>Ledwina L. Gwynn</b>                                                                                                                                                                                                                                                                                |  | DEGREE<br><b>MD</b>                                                                                                               |  | 22c. DATE SIGNED<br><b>4/25/86</b>                                                                                                                                                                                                                                                                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LEDWINA L Gwynn</b>                                                                                                                                                                                                                                                          |  | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>4/23/86</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEMETERY</b>                                                                                                                                                                                                                                                                                                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE (AA Co.) MD.</b>                                                                                                                                                                                                                                              |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE</b>                                            |  |                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 25a. DATE REC'D BY REGISTRAR<br><b>APR 21 1986</b>                                                                                                                                                                                                                                                                       |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. H. Davidson</b>                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                 |  |

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2022 INTERIM BUDGET

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 4 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be called on to certify cause of death.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10636  
REG. NO.

|                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |                                                              |                                                                                                                                                             |                              |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>John D. Dunford</b>                                                                                                                                                                                                            |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 14, 1986</b> |                                                                                                                                                             | 2b. HOUR<br><b>5 30/A</b> M. |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>Black</b>                                                                                                                   |                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-16-1915</b>                                                                                                      |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>71</b>                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Deaton Medical Center</b> |                                                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>                                                                          |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth Steel Co.</b>                                                                 |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                           |                                                              | 13c. CITY OR TOWN<br><b>Baltimore, Maryland</b>                                                                                                             |                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sam D. Dunford</b>                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Irena B. unknown</b>                                                                  |                                                              | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>                                                                          |                              | 16b. SOCIAL SECURITY NO.<br><b>370-28-4252</b>                                                                             |  |
| 17. INFORMANT<br><b>Garnette Dunford</b>                                                                                                                                                                                                                                                      |  | 18. ADDRESS<br><b>815 Winters Lane<br/>Baltimore, Maryland 21228</b>                                                                      |                                                              | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                            |                              |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RLP Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiomyopathy &amp; CHF (H.O.)</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>alcohol abuse</b> |  |                                                                                                                                           |                                                              |                                                                                                                                                             |                              |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                            |  |                                                                                                                                           |                                                              |                                                                                                                                                             |                              |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                |                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                              |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                              |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>18 April 1986</b> to <b>14 April 1986</b> , that (I) (we) lost<br>saw the deceased alive on <b>14 April 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. |  |                                                                                                                                           |                                                              |                                                                                                                                                             |                              |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>J. W. Reed M.D.</b>                                                                                                                                                                                                                                                      |  | DEGREE                                                                                                                                    |                                                              | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                              | 22c. DATE SIGNED<br><b>4/14/86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. W. REED MD</b>                                                                                                                                                                                                                                 |  | 22e. ADDRESS<br><b>6115 CHAS. ST. BALD. MD 21238</b>                                                                                      |                                                              |                                                                                                                                                             |                              |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                 |  | 23b. DATE<br><b>4-21-1986</b>                                                                                                             |                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Vet. Cemetery</b>                                                                                  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                                                        |  |
| 24. FUNERAL DIRECTOR<br><b>Nutter &amp; Sons Funeral Home, Inc.</b>                                                                                                                                                                                                                           |  | ADDRESS<br><b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>                                                                            |                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 15 1986</b>                                                                                                         |                              | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                                                 |  |

BP

Donor: [illegible] Date: [illegible]

Washington City

Washington



00-02622

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                               |  |  |  | 86 10637<br>REG. NO.                                                                         |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|----------------------------------------------------------------------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                             |  |  |  | 2a. DATE OF DEATH                                                                            |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                   |  |  |  | 2b. HOUR                                                                                     |  |  |  |
| 3 SEX                                                                                                                                                                                                                                                                                              |  |  |  | 5. DATE OF BIRTH                                                                             |  |  |  |
| 4 RACE                                                                                                                                                                                                                                                                                             |  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                               |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                          |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                 |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                           |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)                                                                                                                                                                                                |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                         |  |  |  | 13b. COUNTY                                                                                  |  |  |  |
| 13c. CITY OR TOWN                                                                                                                                                                                                                                                                                  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 13e. STREET ADDRESS / ZIP CODE                                                                                                                                                                                                                                                                     |  |  |  | 13f. STREET ADDRESS / ZIP CODE                                                               |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                  |  |  |  | 15. MOTHER'S MAIDEN NAME                                                                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)                                                                                                                                                                                                                                   |  |  |  | 16b. SOCIAL SECURITY NO.                                                                     |  |  |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                      |  |  |  | ADDRESS                                                                                      |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):                                                                                                                                                                                                                            |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                 |  |  |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                       |  |  |  |                                                                                              |  |  |  |
| IMMEDIATE CAUSE (a)                                                                                                                                                                                                                                                                                |  |  |  |                                                                                              |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                     |  |  |  |                                                                                              |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                     |  |  |  |                                                                                              |  |  |  |
| (b)                                                                                                                                                                                                                                                                                                |  |  |  |                                                                                              |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                     |  |  |  |                                                                                              |  |  |  |
| (c)                                                                                                                                                                                                                                                                                                |  |  |  |                                                                                              |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                   |  |  |  |                                                                                              |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                             |  |  |  |                                                                                              |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                   |  |  |  |                                                                                              |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                  |  |  |  |                                                                                              |  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                            |  |  |  |                                                                                              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                  |  |  |  |                                                                                              |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                                                                                                                                                                       |  |  |  |                                                                                              |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                                                                                                                                                                      |  |  |  |                                                                                              |  |  |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                               |  |  |  |                                                                                              |  |  |  |
| 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                 |  |  |  |                                                                                              |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                     |  |  |  |                                                                                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/3/86 to 4/1/86, that (I) (we) lost saw the deceased alive on 4/1/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |                                                                                              |  |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                              |  |  |  |
| 22c. DATE SIGNED                                                                                                                                                                                                                                                                                   |  |  |  |                                                                                              |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                              |  |  |  |                                                                                              |  |  |  |
| 22e. ADDRESS                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                              |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                    |  |  |  |                                                                                              |  |  |  |
| 23b. DATE                                                                                                                                                                                                                                                                                          |  |  |  |                                                                                              |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                 |  |  |  |                                                                                              |  |  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                            |  |  |  |                                                                                              |  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                               |  |  |  |                                                                                              |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                      |  |  |  |                                                                                              |  |  |  |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                         |  |  |  |                                                                                              |  |  |  |

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

APR 04 1986

84350-00



00-04335

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

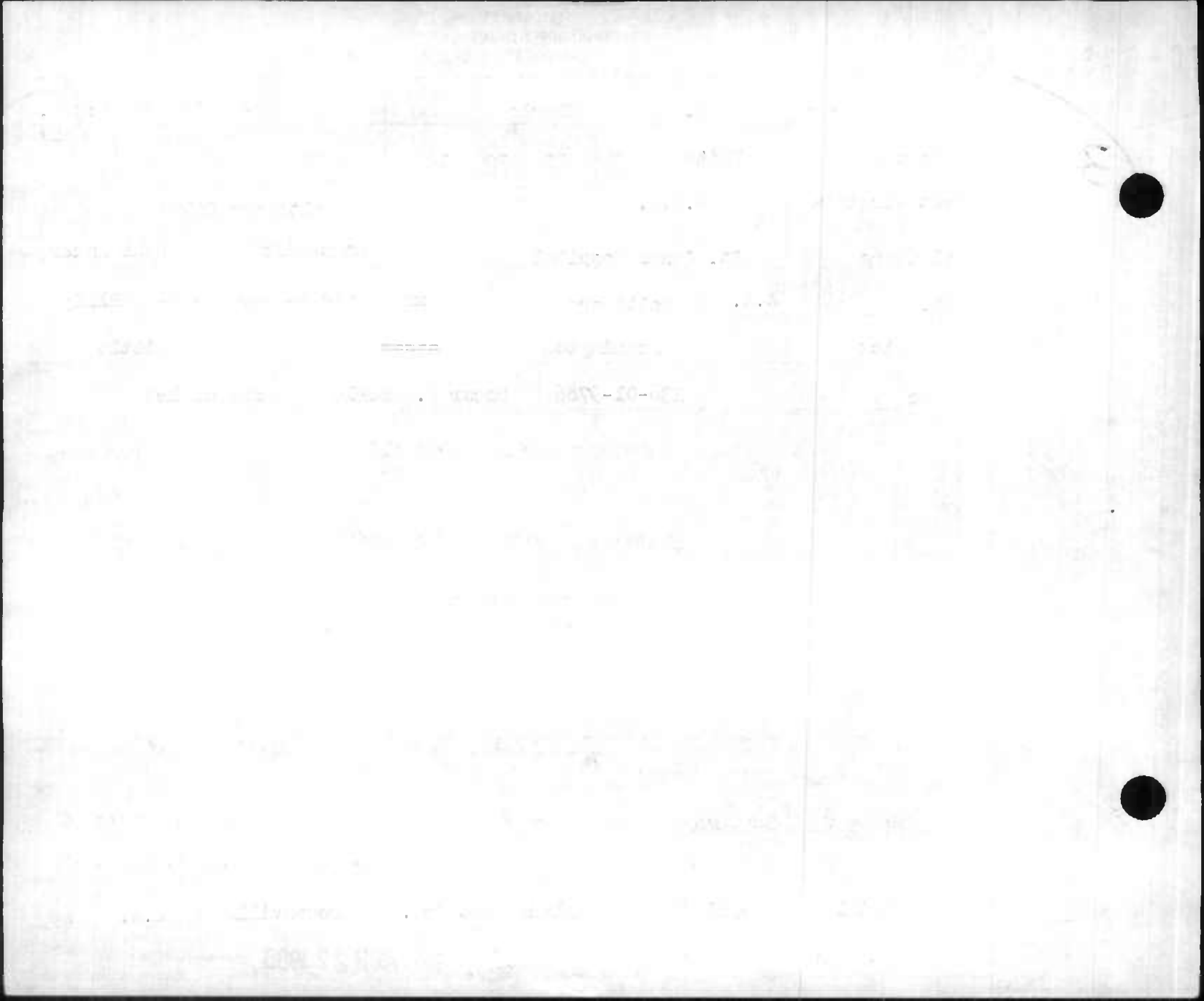
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove accompanying pages and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                          |  |                                                                                                                              |  |                                                                                                                                                             |                                             |                                                                                                                                            |                      |                                                                                                                                       |                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Mona M. Eberle                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                              |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>4 16 86 |                                                                                                                                            | 2b. HOUR<br>3:30P.M. |                                                                                                                                       |                                                                          |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>White                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 30 14                                                                                                                 |                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS                                                                                                  |                      | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                         |                                                                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                 |                      |                                                                                                                                       |                                                                          |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |                                                                                                                                                             |                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                 |                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home Maker                                                                                       |                                                                          |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br>A.A.                                                                                                          |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |                      | 13e. STREET ADDRESS<br>115 Audrey Avenue 21225                                                                                        |                                                                          |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Wick Pennington                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Kittle                                                                         |  |                                                                                                                                                             |                                             |                                                                                                                                            |                      |                                                                                                                                       |                                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>236-01-9786                                                                                      |  | 17. INFORMANT<br>Oscar H. Eberle                                                                                                                            |                                             | ADDRESS<br>Same as 1e3                                                                                                                     |                      |                                                                                                                                       |                                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>SEPSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CHRONIC RENAL FAILURE</u> |  |                                                                                                                              |  |                                                                                                                                                             |                                             |                                                                                                                                            |                      |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES<br>DAYS<br>YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                                              |  |                                                                                                                              |  |                                                                                                                                                             |                                             |                                                                                                                                            |                      |                                                                                                                                       |                                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |  |                                                                                                                                                             |                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                       |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                             |                                                                                                                                            |                      |                                                                                                                                       |                                                                          |
| 21d. INJURY OCCURRED<br>WHILE AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)                                                           |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE                                                                                                  |                                             |                                                                                                                                            |                      |                                                                                                                                       |                                                                          |
| 22a. I certify that (this hospital) attended the deceased from <u>4/16</u> 19 <u>86</u> to <u>4/16</u> 19 <u>86</u> that (we) last saw the deceased alive on <u>4/16</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.                                                  |  |                                                                                                                              |  |                                                                                                                                                             |                                             |                                                                                                                                            |                      |                                                                                                                                       |                                                                          |
| 22b. SIGNATURE<br>Steven H. Pearlman                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                              |  | DEGREE<br>M.D.                                                                                                                                              |                                             | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                      | 22c. DATE SIGNED<br>4/17/86                                                                                                           |                                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEVEN H. PEARLMAN                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                              |  | 22e. ADDRESS<br>ST. AGNES HOSPITAL 900 S. CARON AVE                                                                                                         |                                             |                                                                                                                                            |                      |                                                                                                                                       |                                                                          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br>4/21/86                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Maryland Vets Cem.                                                                                                    |                                             | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>Crownsville A.A. Md                                                                    |                      |                                                                                                                                       |                                                                          |
| 24. FUNERAL DIRECTOR<br>George J. Gonce 4001 Ritchie Hwy, Balto Md                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 22 1986                                                                                                                |                                             | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson                                                                                               |                      |                                                                                                                                       |                                                                          |

BP

DHMH - 16 50M 1/B1  
(VRA 15. 4)



00-04567

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

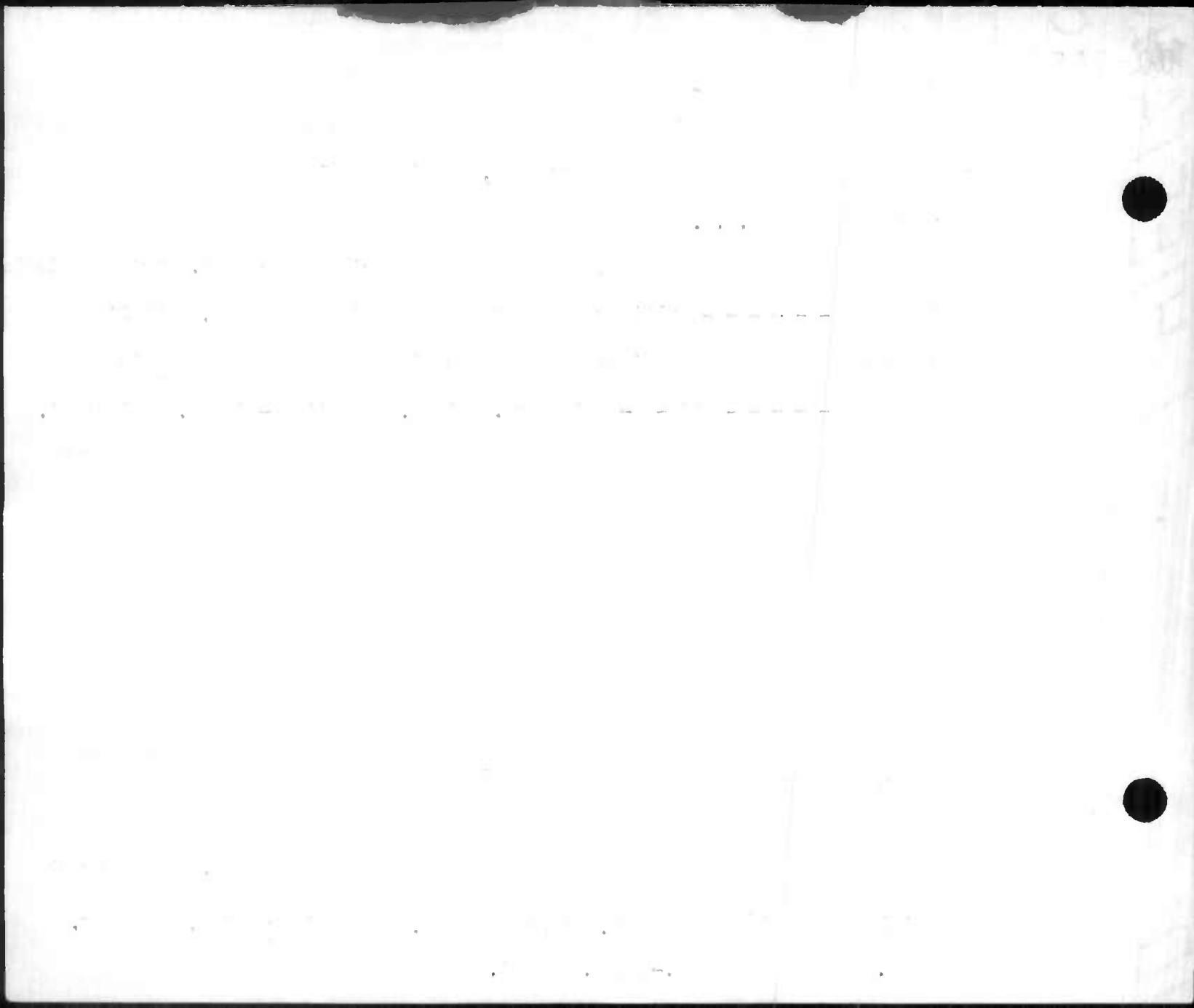
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO. 10639

|                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         |                                                                                                                                                             |                                                                                       |                                                                                                 |                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNA Dora EDER                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 23, 1986                                 |                                                                                                 | 2b. HOUR<br>7:00A M                                                                                                           |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br>Caucasian                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 5, 1924                                                                                                           |                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS                                                       | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.                                                                                  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Drill Press Oper. |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Martin Marietta                                                                          |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | 13b. COUNTY<br>Baltimore                                                                                                                                    | 13c. CITY OR TOWN<br>Baltimore                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>3604 Hudson St. #21224                                                                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Pizlo                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Veronica Cicha                                                                                             |                                                                                       |                                                                                                 |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-18-0554                                                                                      | 17. INFORMANT<br>ADDRESS<br>#21224<br>Mrs. Lois A. Augustine - 408 S. Bouldin St.     |                                                                                                 |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ovarian Carcinoma - Stage IV</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(d) _____ |                                                                                                                                         |                                                                                                                                                             |                                                                                       |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 1/2 yrs ago                                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Terminal Carcinoma</u>                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                             |                                                                                       |                                                                                                 |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                     |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>4/7                                                                               |                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>4/23 1986                                  |                                                                                                                               |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death.                                                                                                                                                          |                                                                                                                                         |                                                                                                                                                             |                                                                                       |                                                                                                 |                                                                                                                               |
| 22b. SIGNATURE<br><u>D. Cho, M.D.</u>                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                       | 22c. DATE SIGNED<br>4/23/86                                                                     |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. Cho, M.D.                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         | 22e. ADDRESS<br>JH 14600 N. Wolfe Street                                                                                                                    |                                                                                       |                                                                                                 |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | 23b. DATE<br>4/26/86                                                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus Cem.                             |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Md.                                                             |
| 24. FUNERAL DIRECTOR<br>NAME<br>George A. Weber & Sons Inc.                                                                                                                                                                                                                                                                                                                      |                                                                                                                                         | ADDRESS<br>-705 S. Ann St.                                                                                                                                  |                                                                                       | 25a. DATE DECEASED BY REGISTRAR<br>APR 24 1986<br>25b. REGISTRAR'S SIGNATURE                    |                                                                                                                               |

BP



00-0443

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610640  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                           |  |                                                                     |  |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                  |  | FIRST MIDDLE LAST                                                                                      |  | 2a. DATE OF DEATH                                                                                                                                         |  | MONTH DAY YEAR                                                      |  | 2b. HOUR                                     |  |
| HILDA                                                                                                                                                                                                                                                                                                                                                                |  | EDLOWITZ                                                                                               |  | 04                                                                                                                                                        |  | 16                                                                  |  | 86                                           |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                          |  | 6. AGE (IN YEARS (LAST BIRTHDAY))                                   |  | 7. IF UNDER 1 YEAR                           |  |
| FEMALE                                                                                                                                                                                                                                                                                                                                                               |  | CAUCASIAN                                                                                              |  | APRIL 6, 1908                                                                                                                                             |  | 78 YRS.                                                             |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                              |  |
| MD                                                                                                                                                                                                                                                                                                                                                                   |  | U.S.A.                                                                                                 |  |                                                                                                                                                           |  | BALTIMORE CITY MD.                                                  |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                              |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                            |  | GOOD SAMARITAN HOSPITAL                                                                                |  | HOUSEWIFE                                                                                                                                                 |  | AT HOME                                                             |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                         |  | 13d. INSIDE CITY LIMITS?                                            |  |                                              |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | BALTIMORE                                                                                                                                                 |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 13e. STREET ADDRESS / ZIP CODE                                                                                                                            |  |                                                                     |  |                                              |  |
| MORRIS                                                                                                                                                                                                                                                                                                                                                               |  | LENA                                                                                                   |  | 2709 JENNER DR., APT, A (21209)                                                                                                                           |  |                                                                     |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT ADDRESS                                                                                                                                     |  |                                                                     |  |                                              |  |
| NO                                                                                                                                                                                                                                                                                                                                                                   |  | 218-10-7834                                                                                            |  | MR. IRVING EDLOW 1613 E. BLUFFDALE RD. 21207                                                                                                              |  |                                                                     |  |                                              |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Poorly differentiated Lymphoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                        |  |                                                                                                                                                           |  |                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                           |  |                                                                     |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                            |  |                                                                     |  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                         |  |                                                                     |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                          |  |                                                                                                        |  |                                                                                                                                                           |  |                                                                     |  |                                              |  |
| 22b. SIGNATURE<br><u>Ram Lal Mittal</u>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                     |  | 22c. DATE SIGNED<br>4/16/86                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAM LAL MITTAL                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 22e. ADDRESS<br>5601 LOCHRAVEN BLVD.<br>BALTIMORE, MD 21239                                                                                               |  |                                                                     |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                        |  | 23d. LOCATION                                                       |  | 23e. COUNTY                                  |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                               |  | 4/17/86                                                                                                |  | MOSES MONTEFIORE CEMETERY                                                                                                                                 |  | BALTIMORE                                                           |  | MARYLAND                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL ELVINSON & SONS, INC.<br>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215                                                                                                                                                                                                                                                            |  |                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | APR 23 1986                                                                                                                                               |  | <u>Sol Elvinson</u>                                                 |  |                                              |  |

19-11-00

COPIES

11/11/00





FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO. 10641

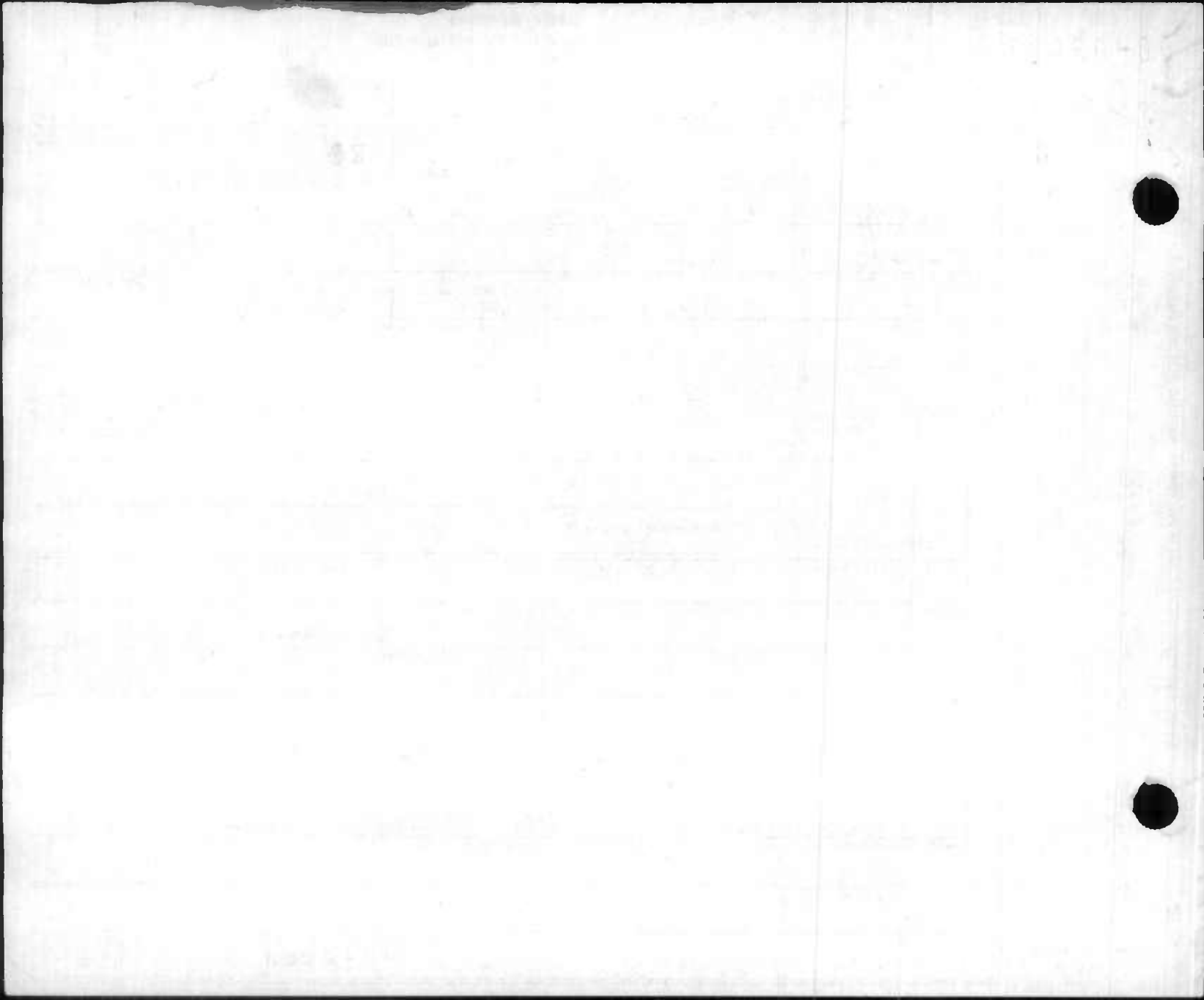
|                                                                                                                                                                                                                                                                                                                                               |                                                                                                                       |                                                                                                                                                              |                                                                                             |                                                                                   |                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------|
| 1. DECEASED NAME (Type or Print) (First, Middle, Last)<br>Isabella Thornton Edmonds                                                                                                                                                                                                                                                           |                                                                                                                       |                                                                                                                                                              | 2a. DATE OF DEATH MONTH DAY YEAR<br>4 14 86                                                 |                                                                                   | 2b. HOUR<br>1:00 AM |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                              | 4. RACE<br>Black                                                                                                      | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 24 05                                                                                                                   | 6. AGE (In years last birthday)<br>80 YRS.                                                  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                     |                     |
| 8. BIRTHPLACE (State or Foreign Country)<br>Md                                                                                                                                                                                                                                                                                                | 9. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                    | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                      |                                                                                   |                     |
| 12. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                        | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address)<br>Sinai Hosp. |                                                                                                                                                              | 14. USUAL OCCUPATION (Type of work for most of working life)                                | 15. KIND OF BUSINESS OR INDUSTRY                                                  |                     |
| 16. USUAL RESIDENCE (If nursing home or other institution, give residence before admission)<br>16a. STATE Md 16b. COUNTY 16c. CITY OR TOWN Baltimore                                                                                                                                                                                          |                                                                                                                       |                                                                                                                                                              | 17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                   |                     |
| 18. FATHER'S NAME FIRST MIDDLE LAST<br>Clinton Ijams                                                                                                                                                                                                                                                                                          |                                                                                                                       |                                                                                                                                                              | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Craig                                    |                                                                                   |                     |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) NO                                                                                                                                                                                                                                                                           |                                                                                                                       |                                                                                                                                                              | 21. SOCIAL SECURITY NO. 214-408320                                                          |                                                                                   |                     |
| 22. INFORMANT ADDRESS<br>Marguerite Thornton 2315 Ashburton St                                                                                                                                                                                                                                                                                |                                                                                                                       |                                                                                                                                                              | 23. STREET ADDRESS / ZIP CODE 21216<br>2315 Ashburton Street                                |                                                                                   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Sepsis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                                                                                                                       |                                                                                                                                                              |                                                                                             |                                                                                   |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                              |                                                                                                                       |                                                                                                                                                              |                                                                                             |                                                                                   |                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                        |                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                             |                                                                                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                            |                                                                                                                       | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                      |                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I or Part 2)    |                     |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                        |                                                                                                                       | 21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)                                                                                          |                                                                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/24 19 86, to 4/14 19 86, that (I) (we) last saw the deceased alive on 4/14 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |                                                                                                                       |                                                                                                                                                              |                                                                                             |                                                                                   |                     |
| 22b. SIGNATURE<br>Eric Weiner MD                                                                                                                                                                                                                                                                                                              |                                                                                                                       |                                                                                                                                                              | 22c. DATE SIGNED<br>4/14/86                                                                 |                                                                                   |                     |
| 22d. PHYSICIAN'S NAME (Type or Print)<br>Eric Weiner MD                                                                                                                                                                                                                                                                                       |                                                                                                                       |                                                                                                                                                              | 22e. ADDRESS<br>Sinai Hosp. of Baltimore                                                    |                                                                                   |                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                           |                                                                                                                       | 23b. DATE<br>4/18/86                                                                                                                                         |                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Md Nat Memorial Park                        |                     |
| 23d. LOCATION CITY OR TOWN<br>Laurel                                                                                                                                                                                                                                                                                                          |                                                                                                                       | 23e. COUNTY<br>Md                                                                                                                                            |                                                                                             | 23f. STATE                                                                        |                     |
| 24. FUNERAL DIRECTOR<br>William C. March F/H West 4300 Wabash Avenue                                                                                                                                                                                                                                                                          |                                                                                                                       |                                                                                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br>APR 18 1986                                                |                                                                                   |                     |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                    |                                                                                                                       |                                                                                                                                                              |                                                                                             |                                                                                   |                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-05147

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, it may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1, 2, and 3 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10642

REG. NO.

|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         |                                                                                                          |                                                                                                                                                             |                                                           |                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                            |                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>AARON A. Edwards                                                                                                                                                                                                                                                                     |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>04 25 86                                                          |                                                                                                                                                             |                                                           | 2b. HOUR<br>4:40 P.M.                                                                                                                                                                                                                                                                                                                   |                                                                                                 |                                                                                                                            |                                                                        |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>W (Caucasian)                                                                                                                |                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 23 73                                                                                                              |                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>12 YRS                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                                                                            |                                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                     |                                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                                                                            |                                                                        |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ. of Maryland Hospital |                                                                                                          |                                                                                                                                                             |                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NONE                                                                                                                                                                                                                                                                |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>= = = =                                                                               |                                                                        |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         | 13b. COUNTY<br>Worcester                                                                                 |                                                                                                                                                             | 13c. CITY OR TOWN<br>Berlin                               |                                                                                                                                                                                                                                                                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>Rte 6, Box 1. 21811                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank G Edwards                                                                                                                                                                                                                                                                   |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Connie M Reed                                           |                                                                                                                                                             |                                                           | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-88-2649 |  |
| 17. INFORMANT<br>Frank G. Edwards                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         | ADDRESS<br>Same as 13e                                                                                   |                                                                                                                                                             |                                                           | 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) respiratory failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) post-shock syndrome |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Renal failure, bleeding diathesis (DIC), sepsis                                                                                                                                         |  |                                                                                                                                         |                                                                                                          |                                                                                                                                                             |                                                           |                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                            |                                                                        |  |
| 19a. DATE OF OPERATION<br>4/17/86                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Scoliosis                                            |                                                                                                                                                             |                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                    |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                               |                                                                                                                                                             |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                                                                                                                                                                                                           |                                                                                                 |                                                                                                                            |                                                                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                   |                                                                                                                                                             |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                            |                                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 18 19 86 to April 25 19 86 that (I) (we) lost<br>saw the deceased alive on April 25 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) did; did not; view the body after death |  |                                                                                                                                         |                                                                                                          |                                                                                                                                                             |                                                           |                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                            |                                                                        |  |
| 22b. SIGNATURE<br>James Chamberlain M.D.                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         | DEGREE                                                                                                   |                                                                                                                                                             |                                                           | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                              |                                                                                                 | 22c. DATE SIGNED<br>4/25/86                                                                                                |                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James Chamberlain                                                                                                                                                                                                                                                                  |  |                                                                                                                                         | 22e. ADDRESS<br>Pediatric Housestaff Ofc.<br>Univ. of Maryland Hosp<br>22 So. Greene St. Baltimore 21201 |                                                                                                                                                             |                                                           |                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                            |                                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                      |  |                                                                                                                                         | 23b. DATE<br>4/28/86                                                                                     |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery |                                                                                                                                                                                                                                                                                                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore A.A. Md                                 |                                                                                                                            |                                                                        |  |
| 24. FUNERAL DIRECTOR<br>George J. Gonce                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         | ADDRESS<br>4001 Ritchie Hgwy Balto Md                                                                    |                                                                                                                                                             |                                                           | 25a. DATE REC'D. BY REGISTRAR<br>APR 29 1986                                                                                                                                                                                                                                                                                            |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>John Davidson                                                                                |                                                                        |  |

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00-05041

Add. Info. Film G623 1/5/87 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10643

FOR  
1- STATE  
REGISTRAR

|                                                                                            |                                                          |                   |                                                                                                                                                          |                                      |                                      |                                |                                   |  |          |  |  |
|--------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------|--------------------------------|-----------------------------------|--|----------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                        |                                                          |                   | FIRST MIDDLE LAST                                                                                                                                        |                                      |                                      | 2a. DATE KNOWN OF DEATH        |                                   |  | 2b. HOUR |  |  |
| Gertrude Ethel Ehling                                                                      |                                                          |                   |                                                                                                                                                          |                                      |                                      | 4/ 16/19 86                    |                                   |  | M        |  |  |
| 3. SEX                                                                                     | 4. RACE                                                  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)                                                                                                                                        | IF UNDER 1 YR.                       | IF UNDER 24 HRS.                     | 2c. DATE PRONOUNCED DEAD       |                                   |  | 2d. HOUR |  |  |
| Female                                                                                     | White                                                    | 8 31 15           | 76 YRS.                                                                                                                                                  | MONTHS                               | DAYS                                 | 4/ 16/19 86                    |                                   |  | P M      |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                  | 7b. CITIZEN OF WHAT COUNTRY?                             |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                |                                   |  |          |  |  |
| Baltimore, Md.                                                                             | U.S.                                                     |                   |                                                                                                                                                          |                                      | Baltimore City, Md.                  |                                |                                   |  |          |  |  |
| 10. CITY OR TOWN OF DEATH                                                                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |                   |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK) |                                      |                                | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |  |  |
| Baltimore                                                                                  | 1308 Aisquith St.                                        |                   |                                                                                                                                                          | Seamstress/Charitable Inst.          |                                      |                                |                                   |  |          |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                                                          |                   |                                                                                                                                                          |                                      |                                      |                                |                                   |  |          |  |  |
| 13a. STATE                                                                                 | 13b. COUNTY                                              | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?                                                                                                                                 | 13e. STREET ADDRESS                  |                                      |                                |                                   |  |          |  |  |
| Md.                                                                                        |                                                          | Balto.            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                      | 1308 Aisquith St. 21203              |                                      |                                |                                   |  |          |  |  |
| 14. FATHER'S NAME                                                                          |                                                          |                   |                                                                                                                                                          |                                      |                                      | 15. MOTHER'S MAIDEN NAME       |                                   |  |          |  |  |
| John Bernard Ehling                                                                        |                                                          |                   |                                                                                                                                                          |                                      |                                      | Susanna Belagyi                |                                   |  |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                               |                                                          |                   |                                                                                                                                                          | 16b. SOCIAL SECURITY NO.             |                                      | 17. INFORMANT ADDRESS          |                                   |  |          |  |  |
| No                                                                                         |                                                          |                   |                                                                                                                                                          | 219-26-3557                          |                                      | Records Deceased provided F.H. |                                   |  |          |  |  |

|                                                                                               |  |                                              |
|-----------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:                                                                   |  |                                              |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease                                   |  |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                |  |                                              |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. |  |                                              |
| (b)                                                                                           |  |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                |  |                                              |
| (c)                                                                                           |  |                                              |

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

|                                                                                                                                                          |  |                                                             |  |                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?                                                                  |  |
|                                                                                                                                                          |  |                                                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
|                                                                                                                                                          |  | P.M. 19                                                     |  |                                                                               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                       |  |
|                                                                                                                                                          |  |                                                             |  |                                                                               |  |

|                                                                           |  |  |  |                 |  |                                                                                                                                                                                                        |  |
|---------------------------------------------------------------------------|--|--|--|-----------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 22a. I certify that I took charge of the remains described above, held on |  |  |  |                 |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion                                                                     |  |
| death resulted from:                                                      |  |  |  |                 |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |
| ACTUAL SIGNATURE                                                          |  |  |  | TITLE (SPECIFY) |  | DATE SIGNED                                                                                                                                                                                            |  |
| Dennis F. Smyth, M.D.                                                     |  |  |  | Assistant       |  | 4/17/86                                                                                                                                                                                                |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                           |  |  |  | ADDRESS         |  |                                                                                                                                                                                                        |  |
| Dennis F. Smyth, M.D.                                                     |  |  |  | 111 Penn St.    |  |                                                                                                                                                                                                        |  |

|                                           |  |           |  |                                    |  |                                         |  |
|-------------------------------------------|--|-----------|--|------------------------------------|--|-----------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |
| Cremation Removal                         |  | 4-23-86   |  | Green Mount Crematory              |  | Balto., Md.                             |  |
| 24. FUNERAL DIRECTOR NAME                 |  |           |  | 25a. DATE REC'D. BY REGISTRAR      |  |                                         |  |
| Anatomy Board                             |  |           |  | APR 29 1986                        |  |                                         |  |
| 25b. REGISTRAR'S SIGNATURE                |  |           |  |                                    |  |                                         |  |
| Stewart & Mowen Co., Balto., Md.          |  |           |  | Julia Davidson-Rendall             |  |                                         |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))



00-05680

12

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                              |  |                                                                                                                       |  |                                            |                                                                                                                                                                     |  |                                                                                  |                                                                               |                                                                                              | 86 10644                                                               |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------|--|--|--|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                       |  |                                            | REG. NO.                                                                                                                                                            |  |                                                                                  |                                                                               |                                                                                              |                                                                        |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GORDON R EINSTEIN                                                                                                                                                                                                                                                                                                        |  |                                                                                                                       |  |                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br>April 27 86                                                                                                                     |  |                                                                                  |                                                                               |                                                                                              | 2b. HOUR<br>2 <sup>30</sup> P.M.                                       |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br>W                                                                                                          |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 23 12 |                                                                                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS                                        |                                                                               |                                                                                              | IF UNDER 1 YEAR MONTHS DAYS                                            |                                                                  | IF UNDER 24 HRS HOURS MIN.                                                                                              |  |  |                                                   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto.                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                   |  |                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |  |                                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto city MD.                        |                                                                                              |                                                                        |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV. HOSP. |  |                                            |                                                                                                                                                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retail Salesman |                                                                               |                                                                                              |                                                                        |                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Freight                                                                            |  |  |                                                   |  |  |  |  |
| 13a. STATE<br>MO                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                       |  |                                            | 13b. COUNTY<br>F U.S.                                                                                                                                               |  | 13c. CITY OR TOWN<br>Balto                                                       |                                                                               | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                        | 13e. STREET ADDRESS / ZIP CODE<br>110 W. UNIVERSITY Parkway 2120 |                                                                                                                         |  |  |                                                   |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Jacob EINSTEIN                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                       |  |                                            | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rosalie Cassandra RICE                                                                                                |  |                                                                                  |                                                                               |                                                                                              |                                                                        |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                               |  |                                                                                                                       |  |                                            | 16b. SOCIAL SECURITY NO.<br>220-07-892                                                                                                                              |  | 17. INFORMANT<br>chant. / wife                                                   |                                                                               |                                                                                              |                                                                        |                                                                  | ADDRESS                                                                                                                 |  |  |                                                   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>metastatic bladder Ca.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>12/85</u> |  |                                                                                                                       |  |                                            |                                                                                                                                                                     |  |                                                                                  |                                                                               |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                              |  |                                                                                                                       |  |                                            |                                                                                                                                                                     |  |                                                                                  |                                                                               |                                                                                              |                                                                        |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                       |  |                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                    |  |                                                                                  |                                                                               |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                                                   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |  |                                                                                                                       |  |                                            | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                             |  |                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                                              |                                                                        |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                            |  |                                                                                                                       |  |                                            | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                  |  |                                                                                  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                                                                                              |                                                                        |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> <u>9/27</u> 19 <u>86</u> to <u>4/27</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/27</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |                                                                                                                       |  |                                            |                                                                                                                                                                     |  |                                                                                  |                                                                               |                                                                                              |                                                                        |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
| 22b. SIGNATURE<br>Mar B Applesstein                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                       |  |                                            | DEGREE<br>MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                  |                                                                               |                                                                                              | 22c. DATE SIGNED<br>9/27/86                                            |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mar B Applesstein                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                       |  |                                            | 22e. ADDRESS<br>c/o UNIV. hosp.                                                                                                                                     |  |                                                                                  |                                                                               |                                                                                              |                                                                        |                                                                  |                                                                                                                         |  |  |                                                   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                       |  |                                            | 23b. DATE<br>4-28-86                                                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY                                               |                                                                               |                                                                                              |                                                                        |                                                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |  |  |                                                   |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Anatomy Board                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                       |  |                                            |                                                                                                                                                                     |  |                                                                                  |                                                                               |                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br>MAY 05 1986                           |                                                                  |                                                                                                                         |  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Pond |  |  |  |  |

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FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610645

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                                 |                                                                                                                                                             |                                                                                      |                                                                   |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Marguerite Carolyn EKLUND                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           | 2a. DATE OF DEATH MONTH DAY YEAR<br>April 3, 1986               |                                                                                                                                                             | 2b. HOUR<br>3:00P M                                                                  |                                                                   |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>White                                                                                                                          |                                                                 | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept 14, 1913                                                                                                            |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>72 YRS. |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                    |                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.       |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5502 Plainfield Avenue 21206 |                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home maker                                                                              |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----                        |                                                                                                                            |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           | 13b. COUNTY<br>-----                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                       |                                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Anthony J Haebler                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary E Brendle |                                                                                                                                                             |                                                                                      |                                                                   |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br>-----<br>219-40-6241                |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>Daniel A Eklund 5502 Plainfield Ave 21206                |                                                                   |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>METASTATIC RENAL CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RESPIRATORY FAILURE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                           |                                                                 |                                                                                                                                                             |                                                                                      |                                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                     |  |                                                                                                                                           |                                                                 |                                                                                                                                                             |                                                                                      |                                                                   |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                                 |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                |                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                      |                                                                   |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                   |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>3/14</u> 19 <u>86</u> , to <u>3/28</u> 19 <u>86</u> , that (I) (we) last saw the deceased <u>on</u> <u>3/28</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                  |  |                                                                                                                                           |                                                                 |                                                                                                                                                             |                                                                                      |                                                                   |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Hector Silva</u>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           |                                                                 | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                      | 22c. DATE SIGNED<br><u>3/28</u>                                   |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Hector Silva, M.D.                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                                 | 22e. ADDRESS<br>Univ of Maryland Hospital Baltimore Md.                                                                                                     |                                                                                      |                                                                   |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>04/07/86                                                                                                                     |                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer Cem                                                                                                |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.       |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dippel Funeral Homes, Inc.<br>7110 Belair Road Baltimore Md. 21206                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>APR 04 1986                                                                                                                |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>       |                                                                                                                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

0-02574

00-02461

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10646

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|-------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THOMAS EDGAR ELIFF                                                                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>04-01-86                                                                                                                                                                                                                                                                                                            |  | 2b. HOUR<br>6-10 AM                                                                                                                                                                                                                                                                                                                                                                           |  |
| 3. SEX<br>Male                                                                                                                      |  | 4. RACE<br>White                                                                                                                                                                                                                                                                                                                                           |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 16 06                                                                                                                                                                                                                                                                                                                                                 |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                                                                                          |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                       |  | 8. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                            |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                          |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital                                                                                                                                                                                                                                                               |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Employed                                                                                                                                                                                                                                                                                                         |  | 13. STREET ADDRESS / ZIP CODE<br>4039 Wilkens Ave., 21229                                                                                                                                                                                                                                                                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John H. Eliff                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary A. Jarboe                                                                                                                                                                                                                                                                                            |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                    |  |
| 16b. SOCIAL SECURITY NO.<br>216-10-8814                                                                                             |  | 17. INFORMANT<br>Margaret Eliff, 4039 Wilkens Avenue, 21229                                                                                                                                                                                                                                                                                                |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Pulmonary edema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>myocardial infarct</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                           |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                                    |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                       |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                        |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                   |  | 22a. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> 19 <u>86</u> , to <u>4/1</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/1</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Latha R. Pillai</u> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                                 |  |
| 22c. DATE SIGNED<br>4/1/86                                                                                                          |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LATHA R. PILLAI                                                                                                                                                                                                                                                                                                   |  | 22e. ADDRESS<br>ST. AGNES HOSPITAL                                                                                                                                                                                                                                                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                 |  | 23b. DATE<br>4/4/86                                                                                                                                                                                                                                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery                                                                                                                                                                                                                                                                                                                                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                          |  | 24. FUNERAL DIRECTOR<br>NAME<br><u>Hubbard Funeral Home</u> ADDRESS                                                                                                                                                                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 03 1986                                                                                                                                                                                                                                                                                                                                                  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Julia D. [Signature]</u>                                                                           |  |                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                               |  |

10-03081

00-02721

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86  
REG. NO.

10647

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Thomas A. Elliott</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 2 1986</b>                                                                                                  |  |                                                                                                                                            |  | 2b. HOUR<br>M                                                                                                              |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>Caucasian</b>                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 9 1905</b>                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>                                                                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                          |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Villa of St. Michael</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sears &amp; Roebuck</b>                                                            |  |
| 13a. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br><b>Maryland Baltimore</b>                                                                                                                                                                                                                                                                             |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8320 Lages Lane 21207</b>                                                                             |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alfred Elliott</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maude Kelly</b>                                                                                         |  |                                                                                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-03-6967</b>                                                            |  | 17. IN BALTIMORE<br><b>Mrs. Celeste Jones</b>                                                                                                               |  | ADDRESS<br><b>8320 Lages Lane Baltimore</b>                                                                                                |  | 21207<br><b>Maryland</b>                                                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of Prostate with</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bone metastases</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Chronic obstructive pulmonary disease</b>                                                                                                                                                                                                                                         |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                                            |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                              |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>G. Kawaja</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | DEGREE                                                                                                                                                      |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/2/86</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TAHOORA KAWAJA</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>8204 Liberty Rd Baltimore MD 21207</b>                                                                                                   |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>4/4/86</b>                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Woodlawn Baltimore Maryland</b>                                                                 |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, Maryland 21133</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 07 1986</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Henderson</b>                                                                               |  |                                                                                                                            |  |

April 1961

General

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10648

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |                                                       |                                                                                                                                                             |                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Webster Ford Elliott</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 20 86</b> |                                                                                                                                                             | 2b. HOUR<br><b>5:30 A.M.</b> |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>White</b>                                                                                                                           |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 29 99</b>                                                                                                        |                              |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                        |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hosp.</b> |                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                                                                                           |                              |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CARPENTER</b>                                                                                                                                                                                                                                                                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF-EMPLOYED</b>                                                                                         |                                                       |                                                                                                                                                             |                              |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                   |                                                       | 13c. CITY OR TOWN<br><b>WOODLAWN</b>                                                                                                                        |                              |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        |  | 13e. STREET ADDRESS / ZIP CODE<br><b>9312 Dogwood Rd. 21207</b>                                                                                   |                                                       |                                                                                                                                                             |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE WEBSTER Elliott</b>                                                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jettie Gattion</b>                                                                            |                                                       |                                                                                                                                                             |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br><b>217-01-9595</b>                                                                                                    |                                                       | 17. INFORMANT ADDRESS<br><b>EUNICE M. HOPE (SAME AS 13E)</b>                                                                                                |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Pulmonary metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Esophageal Ca.</b> |  |                                                                                                                                                   |                                                       |                                                                                                                                                             |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |                                                       |                                                                                                                                                             |                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                  |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                              |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |                                                       |                                                                                                                                                             |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4/20/86</b><br>P.M. 19                                                                      |                                                       | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                            |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>4/13/86 to 4/20/86</b>                                                                              |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/20/86</b> to <b>4/20/86</b> , that (I) (we) last saw the deceased alive on <b>4/20/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                           |  |                                                                                                                                                   |                                                       |                                                                                                                                                             |                              |  |
| 22b. SIGNATURE<br><b>Vazquez</b>                                                                                                                                                                                                                                                                                                                                                                       |  | DEGREE<br><b>M.D.</b>                                                                                                                             |                                                       | 22c. DATE SIGNED<br><b>4/20/86</b>                                                                                                                          |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VAZQUEZ, M.D.</b>                                                                                                                                                                                                                                                                                                                                          |  | 22e. ADDRESS<br><b>South Baltimore General Hospital</b>                                                                                           |                                                       |                                                                                                                                                             |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>4/22/86</b>                                                                                                                       |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk</b>                                                                                              |                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |                                                       |                                                                                                                                                             |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS<br><b>Balto. Md. 21225</b>                                                                                                                |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 22 1986</b>                                                                                                         |                              |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |                                                       |                                                                                                                                                             |                              |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

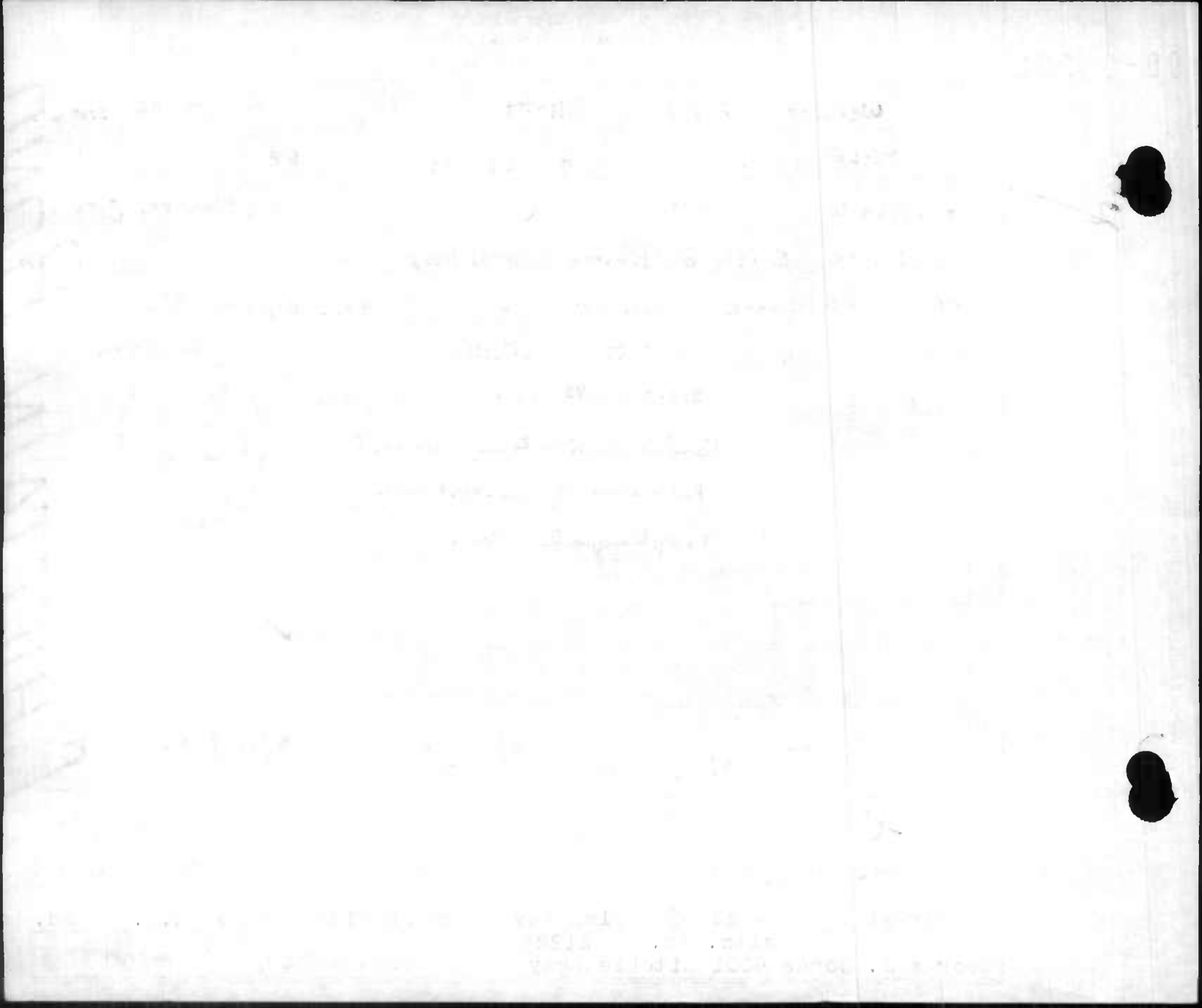
BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified and a copy of this certificate must be furnished to the medical examiner.





00-05100

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                              |  |  |  |  |  |  |  |  |  | 6                                                                                                                                                        | REG. NO. | 10649                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH                                                                                                                                  |          | 2b. HOUR                                                                      |  |
| ALLEN ELLISON                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 4 25 1986                                                                                                                                                |          | M                                                                             |  |
| 3. SEX 4. RACE 5. DATE OF BIRTH 6. AGE (IN YEARS) 7. CITIZEN OF WHAT COUNTRY?                                                                                                                        |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD                                                                                                                                 |          | 2d. HOUR                                                                      |  |
| Male Black 5 22 78 57 YRS. USA                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 4 25 1986                                                                                                                                                |          | 3A M                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                               |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. BALTIMORE CITY OR COUNTY OF DEATH                                          |  |
| Eggs Over S.C. USA                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | Baltimore City                                                                                                                                           |          | MD.                                                                           |  |
| 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                                                                                                   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |          | 12b. KIND OF BUSINESS OR INDUSTRY                                             |  |
| Baltimore University Hospital (STU)                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | Carpenter                                                                                                                                                |          |                                                                               |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS?                                                                                                                                    |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS                                                                                                                                      |          |                                                                               |  |
| Md. Baltimore                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 1102 Lynhurst                                                                                                                                            |          | 21229                                                                         |  |
| 14. FATHER'S NAME 15. MOTHER'S MAIDEN NAME                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                       |          | 16b. SOCIAL SECURITY NO.                                                      |  |
| Rivers Ellison                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | yes WW II                                                                                                                                                |          | 248-30-7822                                                                   |  |
| 17. INFORMANT ADDRESS                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |
| Katherine Ellison 1102 Lynhurst                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 8811 IMMEDIATE CAUSE (a) Closed head trauma                                                                                                              |          |                                                                               |  |
|                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                       |          |                                                                               |  |
|                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | (c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                       |          |                                                                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                       |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |          |                                                                               |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                             |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?                                                                                                                                             |          |                                                                               |  |
|                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                      |          |                                                                               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                       |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
|                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 7:15 PM 4-21- 1986                                                                                                                                       |          | Subject fell from scaffold.                                                   |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>                       |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                              |          | 21f. LOCATION CITY OR TOWN COUNTY STATE                                       |  |
|                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | construction site                                                                                                                                        |          | Dorsey Run Waste Water Treatment Center, MD                                   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:                                                                                                       |  |  |  |  |  |  |  |  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>                                         |          | and in my opinion                                                             |  |
| Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | TITLE (SPECIFY)                                                                                                                                          |          | DATE SIGNED                                                                   |  |
| ACTUAL SIGNATURE                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | M.D. Assistant                                                                                                                                           |          | 4-25-86                                                                       |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | ADDRESS                                                                                                                                                  |          |                                                                               |  |
| Ann M. Dixon, M.D.                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 111 Penn St., Balto., MD                                                                                                                                 |          | 21201                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                            |  |  |  |  |  |  |  |  |  | 23b. DATE                                                                                                                                                |          | 23c. NAME OF CEMETERY OR CREMATORY                                            |  |
| Burial                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | 4-30-86                                                                                                                                                  |          | Crownsville                                                                   |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |          | 25b. REGISTRAR'S SIGNATURE                                                    |  |
| JAS. A. Morbentons                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 1701 Laurens                                                                                                                                             |          | APR 29 1986                                                                   |  |
| 23d. LOCATION CITY OR TOWN                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 23e. COUNTY                                                                                                                                              |          | 23f. STATE                                                                    |  |
| Crownsville                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | Miles                                                                                                                                                    |          | Md.                                                                           |  |

RECEIVED  
JAN 10 1953



00-04725

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

850

10650

REG. NO.

|                                                         |                                                                                                                                     |                                                                                                                                                            |                                                       |                                                                                             |                                           |
|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THEO ELMORE      |                                                                                                                                     |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 21, 1986 |                                                                                             | 2b. HOUR<br>8:00P M                       |
| 3 SEX<br>Female                                         | 4 RACE<br>Black                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 10 22                                                                                                              |                                                       | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS                                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Florida | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                       | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                   |                                           |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |                                                                                                                                                            |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Produce Dept. Ft. Meade |                                           |

|                                                                                                                                                  |  |                                                                        |                                                                                                 |                                                                           |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Baltimore |  |                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2517 Park Heights Terrace 21215                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jim Johnson                                                                                            |  |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anita Sherman                                  |                                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>365 38-7745 |                                                                                                 | 17. INFORMANT<br>ADDRESS<br>Choice Elmore 2517 Park Heights Terrace 21215 |  |

|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypotension<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Extensive MI<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Chilled Bypass Graft to CAD |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour<br>4 days<br>4/17/86 (4 days) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|                                                                                                                                                                                                                                                                                                  |  |                                                                    |  |                                                                                |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br>4/14/86                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CAD            |  | 20a. AUTOPSY?<br>YES NO <input checked="" type="checkbox"/>                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) this hospital attended the deceased from 4/21 19 86 to 4/21 19 86, that (I) (we) last saw the deceased at or on 4/21 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not saw the body after death. |  |                                                                    |  |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br>C. Tan                                                                                                                                                                                                                                                                         |  | DEGREE                                                             |  | 22c. DATE SIGNED<br>4/21/86                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. TAN                                                                                                                                                                                                                                                  |  | 22e. ADDRESS<br>Johns Hopkins Hospital                             |  |                                                                                |                                                                                                                            |

|                                                            |                      |                                                              |                                                               |
|------------------------------------------------------------|----------------------|--------------------------------------------------------------|---------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial     | 23b. DATE<br>4-28-86 | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Ford Veterans | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dwight Mills Md |
| 24. FUNERAL DIRECTOR<br>March F.H. West 4300 Wabash Avenue |                      | 25a. DATE RECD. BY REGISTRAR<br>APR 25 1986                  | 25b. REGISTRAR'S SIGNATURE                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires the death certificate to be executed within 24 hours after death. Page-4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

000 08199A

00-04001

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                     |  |                                                                                                 |                                                                                                                                                             |                                                                               |                                                            |                                   |                                                                 | REG. NO. 0651                                                                       |                      |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Evelyn V. Emerson                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                     |  |                                                                                                 |                                                                                                                                                             |                                                                               |                                                            |                                   |                                                                 | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>4/ 15/ 19 86                           |                      | 2b. HOUR<br>M<br>9:45                        |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 13 19                                                                                       |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>65 YRS.                                                   | IF UNDER 1 YR.<br>MONTHS DAYS<br>HOURS MIN.                                                                                                                 |                                                                               | IF UNDER 24 HRS.<br>HOURS MIN.                             |                                   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>4/ 15/ 19 86      |                                                                                     | 2d. HOUR<br>A M<br>A |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                                                                                                       |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                 |  |                                                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD |                                   |                                                                 |                                                                                     |                      |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4802 Reisterstown Rd. |  |                                                                                                 |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired      |                                                            | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                 |                                                                                     |                      |                                              |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                     |  |                                                                                                 |                                                                                                                                                             |                                                                               |                                                            |                                   |                                                                 |                                                                                     |                      |                                              |
| 13b. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 13c. CITY OR TOWN<br>Balto.                                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                                             | 13e. STREET ADDRESS<br>4802 Reisterstown Rd. 21215                            |                                                            |                                   |                                                                 |                                                                                     |                      |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Scott                                                                                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                     |  |                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mollie Newsome                                                                                             |                                                                               |                                                            |                                   |                                                                 |                                                                                     |                      |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>220-22-1729                                                         |                                                                                                                                                             | 17. INFORMANT<br>Daniel Emerson                                               |                                                            |                                   | ADDRESS<br>4802 Reisterstown Rd.                                |                                                                                     |                      |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cancer of Breast<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                    |                  |                                                                                                                                     |  |                                                                                                 |                                                                                                                                                             |                                                                               |                                                            |                                   |                                                                 |                                                                                     |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                     |  |                                                                                                 |                                                                                                                                                             |                                                                               |                                                            |                                   |                                                                 |                                                                                     |                      |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                               |                                                                                                                                                             |                                                                               |                                                            |                                   |                                                                 | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                      |                                              |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                            |                                   |                                                                 |                                                                                     |                      |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                     |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                            |                                   |                                                                 |                                                                                     |                      |                                              |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                  |                                                                                                                                     |  |                                                                                                 |                                                                                                                                                             |                                                                               |                                                            |                                   |                                                                 |                                                                                     |                      |                                              |
| ACTUAL SIGNATURE<br>Margarita A. Korell                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                     |  | TITLE (SPECIFY)<br>M.D. Assistant                                                               |                                                                                                                                                             |                                                                               |                                                            | DATE SIGNED<br>9/15/86            |                                                                 |                                                                                     |                      |                                              |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                     |  | ADDRESS<br>111 Penn St.                                                                         |                                                                                                                                                             |                                                                               |                                                            |                                   |                                                                 |                                                                                     |                      |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                     |  | 23b. DATE<br>4/19/86                                                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Pk.                           |                                                            |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown, Md. |                                                                                     |                      |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F.H. West                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                     |  |                                                                                                 |                                                                                                                                                             | ADDRESS<br>4300 Wabash Ave.                                                   |                                                            | 25a. DATE REC'D. BY REGISTRAR     |                                                                 | 25b. REGISTRAR'S SIGNATURE                                                          |                      |                                              |

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

APR 18 1986

1. The first part of the report is a general  
 introduction to the project. It describes the  
 objectives of the study and the methods used to  
 collect the data. The introduction also mentions  
 the importance of the project and the need for  
 further research in this area.

2. The second part of the report is a detailed  
 description of the data collection process. It  
 explains how the data was collected and how it  
 was analyzed. This part of the report is  
 important because it provides a clear and  
 concise summary of the data collection process.

3. The third part of the report is a discussion  
 of the results of the study. It compares the  
 results of the study with the results of other  
 studies in this area. The discussion also  
 mentions the limitations of the study and the  
 need for further research in this area.

00-05269

Items #1 &amp; 14 5/23/86 mth

FOR  
1 - STATE per phone F.H.  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10652  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |                                                              |                                                                                      |                           |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Dorothy ENGEL Engle</b>                                                                                                                                                                                                                                                     |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 25, 1986</b> |                                                                                      | 2b. HOUR<br><b>3 P.M.</b> |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>WHITE</b>                                                                                                                     |                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 12 1908</b>                              |                           |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |                                                              | 8. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>78</b>                                  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3701 CLARKS LA., APT. D</b> |                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                    |                           |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                             |                                                              | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ABRAHAM ENGEL Engle</b>                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH UNKNOWN</b>                                                                       |                                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ACCOUNTING</b>                               |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>262-037117A</b>                                                                                              |                                                              | 17. INFORMANT<br><b>MRS. ANN BERLIN APT. 409</b>                                     |                           |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>STROKE</b>                                                                                                                                                                                              |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>EMBOLISM</b>                                                                                       |                                                              | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RHEUMATIC HEART DISEASE MITRAL + AORTIC</b> |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>CONGESTIVE HEART FAILURE</b>                                                                                                                                                                      |  |                                                                                                                                             |                                                              |                                                                                      |                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)      |                           |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 70</b> , to <b>25 April 19 86</b> , that (I) (we) last saw the deceased alive on <b>25 April 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                             |                                                              |                                                                                      |                           |  |
| 22b. SIGNATURE<br><b>Abraham Genecin M.D.</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |                                                              | 22c. DATE SIGNED<br><b>25 April 1986</b>                                             |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ABRAHAM GENECIN, M.D.</b>                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS<br><b>611 PARK AVE. BALTO., MD</b>                                                                                             |                                                              |                                                                                      |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>APR. 27, 1986</b>                                                                                                           |                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW FRIENDSHIP</b>                       |                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                                                                                                                                                                                                                                                                    |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>                         |                                                              |                                                                                      |                           |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>APR 30 1986</b>                                                                                                                                                                                                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                  |                                                              |                                                                                      |                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general description of the project.

2. The second part is a detailed description of the methodology used.

3. The third part is a description of the results of the study.

4. The fourth part is a discussion of the implications of the findings.

5. The fifth part is a conclusion and a list of references.

6. The sixth part is a list of appendices.

7. The seventh part is a list of figures and tables.

8. The eighth part is a list of footnotes.

9. The ninth part is a list of acknowledgments.

10. The tenth part is a list of references.

11. The eleventh part is a list of appendices.

12. The twelfth part is a list of figures and tables.

13. The thirteenth part is a list of footnotes.

14. The fourteenth part is a list of acknowledgments.

15. The fifteenth part is a list of references.

16. The sixteenth part is a list of appendices.

17. The seventeenth part is a list of figures and tables.

18. The eighteenth part is a list of footnotes.



00-05131

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 6 5 3  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Casper BENNETT Epps</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                               |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 26, 1986</b>                                    |                                                                                      | 2b. HOUR<br><b>12:25P</b>                                                                                                             |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br><b>B</b>                                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 1 31</b>                                                                                                         |                                                                                                 | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>55</b> YRS.                                  |                                                                                                                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |                                                                                                                                       |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 13b. COUNTY                                                                                                                                   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2103 SINCLAIR LANE 21213</b>                    |                                                                                                                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT EPPS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH SAVAGE</b>                                                                                        |                                                                                                 |                                                                                      |                                                                                                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>218222414</b>                                                                                                                | 17. INFORMANT ADDRESS<br><b>NOLLIE EPPS 2103 SINCLAIR LANE</b>                                  |                                                                                      |                                                                                                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Subacute Bacterial Endocarditis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Old Rheumatic Valvulitis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                         |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)<br><b>Exogenous Obesity</b>                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                                                                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                                       |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 24</b> , 19 <b>86</b> , to <b>April 26</b> , 19 <b>86</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 26</b> , 19 <b>86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                                       |
| 22b. SIGNATURE<br><b>Thomas Ganey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                               | DEGREE                                                                                                                                                      |                                                                                                 | 22c. DATE SIGNED<br><b>4/26/86</b>                                                   |                                                                                                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas Ganey, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                               | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                        |                                                                                                 |                                                                                      |                                                                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23b. DATE<br><b>5-2-86</b>                                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS</b>                                                                                                        |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ARBUTUS MARYLAND</b>                |                                                                                                                                       |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WM.C.MARCH F/H INC. 1101 E.NORTH AVE.</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                               | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>APR 29 1986</b>                                                                              |                                                                                                 |                                                                                      |                                                                                                                                       |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1-10-1911

00-05730

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10054  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                                            |                                                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Cecil</b>                                                                                                                                                                                                                                                                                                                       |  |  | FIRST MIDDLE LAST                                                                                                                             |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 27, 1986</b>                                                                                                |  |  | 2b. HOUR<br><b>1:00P.M.</b>                                                                                                |                                                                |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                     |  |  | 4. RACE<br><b>White</b>                                                                                                                       |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 3 41</b>                                                                                                         |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>45</b> YRS.                                                                          |                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                              |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                                           |                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                             |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                  |  |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                                  |  |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Russell</b> <b>Estes</b>                                                                                                                                                                                                                                                                                                     |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth</b> <b>Campbell</b>                                                                  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                          |  |  | 16b. SOCIAL SECURITY NO.<br><b>230-50-0969</b>                                                                             |                                                                |  |
| 17. INFORMANT<br><b>Ms. Cindy Estes</b>                                                                                                                                                                                                                                                                                                                                   |  |  | 473 ADDRESS<br><b>N. Augusta Ave.</b>                                                                                                         |  |  | Waynesboro, Va.                                                                                                                                             |  |  |                                                                                                                            |                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anoxic Encephalopathy</b>                                                                                                                                                                                                              |  |  |                                                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Days</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Delirium Tremens</b>                                                                                                                                                                                                           |  |  |                                                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                                            | <b>Days</b>                                                    |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Alcohol Abuse</b>                                                                                                                                                                                                                                                                                                                |  |  |                                                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                                            | <b>Years</b>                                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Intravenous Drug Abuse</b>                                                                                                                                                                                                     |  |  |                                                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                                            |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |  |                                                                                                                            |                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                            |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |  |                                                                                                                            |                                                                |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>April 8,</b> 19 <b>86</b> , to <b>April 27,</b> 19 <b>86</b> , that (X) (we) last saw the deceased alive on <b>April 27,</b> 19 <b>86</b> , and that in (X) (our) opinion death occurred on the date and hour and I am the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |                                                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                                            |                                                                |  |
| 22b. SIGNATURE<br><b>DR. ROANO</b>                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                                                               |  |  | DEGREE<br><b>MD</b>                                                                                                                                         |  |  | 22c. DATE SIGNED<br><b>4/27/86</b>                                                                                         |                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROANO</b>                                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                                                               |  |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                        |  |  |                                                                                                                            |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                            |  |  | 23b. DATE<br><b>4-28-86</b>                                                                                                                   |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                 |                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>                                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                                                               |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 05 1986</b>                                                                                                         |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John L. ...</b>                                                                           |                                                                |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-00000



00-01389

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGES 2, 3, AND 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 2 AND 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                          |                                                                          |                                                                                                                                                             |                  |                                                                                                                              |                                                               |                                                                                     |  | REG. NO. 0055                                                                                   |                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARY G. EVANS</b>                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                          |                                                                          |                                                                                                                                                             |                  |                                                                                                                              |                                                               |                                                                                     |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>3-23-86 19</b> | 2b. HOUR<br><b>M</b> |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>Cauc.</b> | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3/3/25</b>                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>61 YRS.</b> | IF UNDER 1 YR.                                                                                                                                              | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD<br><b>3-23-86 19</b>                                                                                | 7d. HOUR<br><b>8:55</b>                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |  |                                                                                                 |                      |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                           |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                                                |                                                               | 12b. KIND OF BUSINESS<br><b>Levinson &amp; Klein</b>                                |  |                                                                                                 |                      |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                            |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |                                                                          |                                                                                                                                                             |                  | 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>13a. STATE<br/>Md.</b> |                                                               | 13b. COUNTY<br><b>-</b>                                                             |  |                                                                                                 |                      |
| 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                             |                                                                          | 13e. STREET ADDRESS<br><b>3812 Elmora Ave.</b>                                                                                                              |                  | 21213                                                                                                                        |                                                               |                                                                                     |  |                                                                                                 |                      |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John A. Knighton</b>                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                          |                                                                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Catherine Mannion</b>                                                                                      |                  |                                                                                                                              |                                                               |                                                                                     |  |                                                                                                 |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                          |                         | 16b. SOCIAL SECURITY NO.<br><b>216-20-3805</b>                                                                                           |                                                                          | 17. INFORMANT ADDRESS<br><b>Timothy Evans, 1131 Bradley Rd. Pasadena, Md.</b>                                                                               |                  |                                                                                                                              |                                                               |                                                                                     |  |                                                                                                 |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anoxic encephalopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                                                                                                                                    |                         |                                                                                                                                          |                                                                          |                                                                                                                                                             |                  |                                                                                                                              |                                                               |                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>21222</b>                                    |                      |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                          |                                                                          |                                                                                                                                                             |                  |                                                                                                                              |                                                               |                                                                                     |  |                                                                                                 |                      |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                          |                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |                  |                                                                                                                              |                                                               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                                                                 |                      |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>P.M. 19</b>                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                          |                                                                          | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                              |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                |                                                               |                                                                                     |  |                                                                                                 |                      |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                          |                                                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                 |                  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                               |                                                               |                                                                                     |  |                                                                                                 |                      |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |                                                                                                                                          |                                                                          |                                                                                                                                                             |                  |                                                                                                                              |                                                               |                                                                                     |  |                                                                                                 |                      |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                          |                                                                          | TITLE (SPECIFY)<br><b>M.D. Assistant</b>                                                                                                                    |                  |                                                                                                                              |                                                               | DATE SIGNED <b>3-24-86</b>                                                          |  |                                                                                                 |                      |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                          |                                                                          | ADDRESS<br><b>111 Penn Street</b>                                                                                                                           |                  |                                                                                                                              |                                                               |                                                                                     |  |                                                                                                 |                      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                               |                         | 23b. DATE<br><b>3/26/86</b>                                                                                                              |                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>                                                                                             |                  |                                                                                                                              | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b> |                                                                                     |  |                                                                                                 |                      |
| 24. FUNERAL DIRECTOR<br><b>Schmunke Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                          |                                                                          |                                                                                                                                                             |                  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>                                                                          |                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                                  |  |                                                                                                 |                      |
| 3331 Brehms Lane, Balto., Md.                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                          |                                                                          |                                                                                                                                                             |                  | 21213                                                                                                                        |                                                               |                                                                                     |  |                                                                                                 |                      |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| FOR<br>1- STATE 4/9/86 rja<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                       |                                               | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |                                                                                   | 86 10656<br>REG. NO.                                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Thomas Longley Fair, Jr.</b>                                                                                                                                                                                                                                                                                                                                                   |                                               |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 4 86</b><br>2b. HOUR<br><b>4 P.M.</b> |                                                                                                                                                  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 2 10</b>                                                                                                        |                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John Deaton Medical Center</b>              |                                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b><br>12b. KIND OF BUSINESS OR INDUSTRY<br><b>Electrical</b> |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                               | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br><b>Baltimore</b>                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Longley Fair, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                     |                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Henrietta Miller</b>                                                                                    |                                                                                   | 13e. STREET ADDRESS / ZIP CODE<br><b>3213 Evergreen Ave. 21214</b>                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                             |                                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-05-4789</b>                                                                               |                                                                                   | 17. INFORMANT<br>ADDRESS<br><b>Edna M. Fair same as 13e</b>                                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Prostatic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 yrs. 7 mos.</b> |                                               |                                                                                                                                                             |                                                                                   |                                                                                                                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                                          |                                               |                                                                                                                                                             |                                                                                   |                                                                                                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                        |                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                      |                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                |                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/2</b> , 19 <b>86</b> , to <b>4/4</b> , 19 <b>86</b> that (I) (we) lost<br>saw the deceased alive on <b>4/4</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.                                                                                 |                                               |                                                                                                                                                             |                                                                                   |                                                                                                                                                  |  |
| 22b. SIGNATURE<br><b>R Kolodnyuk MD</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                                               | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                   | 22c. DATE SIGNED<br><b>4/4/86</b>                                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KOLODNYUK</b>                                                                                                                                                                                                                                                                                                                                                                                     |                                               | 22e. ADDRESS<br><b>Deaton Medical Center</b>                                                                                                                |                                                                                   |                                                                                                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                 |                                               | 23b. DATE<br><b>4/8/1986</b>                                                                                                                                |                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                                                                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                      |                                               | 23e. DATE REC'D. BY REGISTRAR<br><b>APR 11 1986</b>                                                                                                         |                                                                                   |                                                                                                                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                              |                                               | 25a. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                            |                                                                                   |                                                                                                                                                  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610657

REG NO.

|                                                                                                                                                                                                                                                                                                        |         |                                                                                                                                      |  |                                                                                                                                                          |        |                                                                     |                   |                                                                                                                                                    |     |                                                                                                   |                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------------------|-------------------|
| 1- FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                           |         | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                  |  | FIRST                                                                                                                                                    | MIDDLE | LAST                                                                | 2a. DATE OF DEATH | MONTH                                                                                                                                              | DAY | YEAR                                                                                              | 2b. HOUR          |
|                                                                                                                                                                                                                                                                                                        |         | LENA M. FALBO                                                                                                                        |  |                                                                                                                                                          |        |                                                                     | APRIL 12, 1986    |                                                                                                                                                    |     |                                                                                                   | 9:11 <sup>A</sup> |
| 3. SEX                                                                                                                                                                                                                                                                                                 | 4. RACE | 5. DATE OF BIRTH                                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                          |        | 7. IF UNDER 1 YEAR                                                  |                   | 8. IF UNDER 24 HRS.                                                                                                                                |     |                                                                                                   |                   |
| Female                                                                                                                                                                                                                                                                                                 | White   | 9 28 1905                                                                                                                            |  | 80 YRS.                                                                                                                                                  |        |                                                                     |                   |                                                                                                                                                    |     |                                                                                                   |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                              |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                   | 10. BALTIMORE CITY                                                                                                                                 |     | MD.                                                                                               |                   |
| Switzerland                                                                                                                                                                                                                                                                                            |         | Switzerland                                                                                                                          |  |                                                                                                                                                          |        |                                                                     |                   |                                                                                                                                                    |     |                                                                                                   |                   |
| 11. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                              |         | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                               |  | 13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |        | 13b. KIND OF BUSINESS OR INDUSTRY                                   |                   | 14. Own Home                                                                                                                                       |     |                                                                                                   |                   |
| BALTIMORE                                                                                                                                                                                                                                                                                              |         | JOHNS HOPKINS HOSPITAL                                                                                                               |  |                                                                                                                                                          |        |                                                                     |                   |                                                                                                                                                    |     |                                                                                                   |                   |
| 15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                           |         | 15b. COUNTY                                                                                                                          |  | 15c. CITY OR TOWN                                                                                                                                        |        | 15d. INSIDE CITY LIMITS?                                            |                   | 15e. STREET ADDRESS                                                                                                                                |     | 15f. ZIP CODE                                                                                     |                   |
| Maryland                                                                                                                                                                                                                                                                                               |         | Baltimore                                                                                                                            |  | Dundalk                                                                                                                                                  |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   | 211 Patapsco Avenue                                                                                                                                |     | 21222                                                                                             |                   |
| 16. FATHER'S NAME                                                                                                                                                                                                                                                                                      |         | 16. MOTHER'S MAIDEN NAME                                                                                                             |  | 17. INFORMANT                                                                                                                                            |        | 17. ADDRESS                                                         |                   | 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                   |     | 18. SOCIAL SECURITY NO.                                                                           |                   |
| Carlo                                                                                                                                                                                                                                                                                                  |         | Bonincontri                                                                                                                          |  | Angelina                                                                                                                                                 |        | Louesa                                                              |                   | No                                                                                                                                                 |     | 212-36-7643                                                                                       |                   |
| 19. JEWELRY                                                                                                                                                                                                                                                                                            |         | 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                            |  | 21. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)                                                                                                      |        | 22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |                   | 23. DUE TO, OR AS A CONSEQUENCE OF                                                                                                                 |     | 24. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |                   |
|                                                                                                                                                                                                                                                                                                        |         | RESPIRATORY ARREST                                                                                                                   |  |                                                                                                                                                          |        | 30 MINUTES                                                          |                   | LEFT LOWER LOBE PNEUMONIA                                                                                                                          |     | 2 WEEKS                                                                                           |                   |
|                                                                                                                                                                                                                                                                                                        |         | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) |  |                                                                                                                                                          |        |                                                                     |                   |                                                                                                                                                    |     |                                                                                                   |                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                 |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  | 20a. AUTOPSY?                                                                                                                                            |        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |     | 21b. TIME OF INJURY                                                                               |                   |
|                                                                                                                                                                                                                                                                                                        |         |                                                                                                                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |        | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                   |                                                                                                                                                    |     | HOUR A.M. MONTH DAY YEAR                                                                          |                   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)                                                                                                                                                                                                                         |         | 21d. INJURY OCCURRED                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |        | 21f. LOCATION                                                       |                   | 21g. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                             |     | 21h. CITY OR TOWN                                                                                 |                   |
|                                                                                                                                                                                                                                                                                                        |         |                                                                                                                                      |  |                                                                                                                                                          |        | STREET                                                              |                   |                                                                                                                                                    |     | COUNTY                                                                                            |                   |
|                                                                                                                                                                                                                                                                                                        |         |                                                                                                                                      |  |                                                                                                                                                          |        | CITY OR TOWN                                                        |                   |                                                                                                                                                    |     | STATE                                                                                             |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/8 to 4/12, 1986 that (I) (we) lost saw the deceased alive on 4/12, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         | 22b. SIGNATURE                                                                                                                       |  | 22c. DEGREE                                                                                                                                              |        | 22d. DATE SIGNED                                                    |                   | 22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |     | 22f. ADDRESS                                                                                      |                   |
|                                                                                                                                                                                                                                                                                                        |         | Carolyn B. Hendricks                                                                                                                 |  | MD                                                                                                                                                       |        | 4/12/86                                                             |                   |                                                                                                                                                    |     | 682 N. Waver St, Baro 21205                                                                       |                   |
| 22g. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                  |         | 22h. ADDRESS                                                                                                                         |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                |        | 23b. DATE                                                           |                   | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                 |     | 23d. LOCATION                                                                                     |                   |
| CAROLYN B. HENDRICKS                                                                                                                                                                                                                                                                                   |         | 682 N. Waver St, Baro 21205                                                                                                          |  | Burial                                                                                                                                                   |        | 4/15/1986                                                           |                   | Oak Lawn Cemetery                                                                                                                                  |     | Baltimore                                                                                         |                   |
| 23e. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                  |         | 23f. DATE REC'D BY REGISTRAR                                                                                                         |  | 23g. REGISTRAR'S SIGNATURE                                                                                                                               |        | 23h. REGISTRAR'S SIGNATURE                                          |                   | 23i. REGISTRAR'S SIGNATURE                                                                                                                         |     | 23j. REGISTRAR'S SIGNATURE                                                                        |                   |
| Duda-Ruck, Inc.                                                                                                                                                                                                                                                                                        |         | APR 15 1986                                                                                                                          |  | June Carter                                                                                                                                              |        |                                                                     |                   |                                                                                                                                                    |     |                                                                                                   |                   |
| 7922 Wise Avenue                                                                                                                                                                                                                                                                                       |         | Dundalk, Maryland 21222                                                                                                              |  |                                                                                                                                                          |        |                                                                     |                   |                                                                                                                                                    |     |                                                                                                   |                   |

10/10/50

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*


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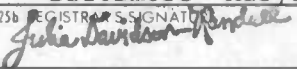
1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 6 5 8  
REG. NO.

|                                                                                   |                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                    |                                                              |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Charles E Falter</b>                       |                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 25 86</b>                                           |                                                                    | 2b. HOUR<br><b>10:48p</b>                                    |
| 3. SEX<br><b>Male</b>                                                             | 4. RACE<br><b>White</b>                                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 12 02</b>                                                                                                        |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                  |                                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |                                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                |                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B&amp;O Railroad</b> |
| 13a. STATE<br><b>Maryland</b>                                                     | 13b. COUNTY<br><b>Baltimore</b>                                                                                                        | 13c. CITY OR TOWN<br><b>Woodlawn</b>                                                                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>7007 Gaymount Road, 21207</b> |                                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John T. Falter</b>                   |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estella G. Loeffler</b>                                                                                 |                                                                                                 |                                                                    |                                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>705-05-4859</b>                                                          | 17. INFORMANT<br>ADDRESS<br><b>Frank Gardner, 7007 Gaymount Road, 21207</b>                                                                                 |                                                                                                 |                                                                    |                                                              |

|                                                                                                                                                         |  |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line in 18a, 18b, and 18c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                        |  | (b) <b>Severe COPD and bronchiectasis</b>       |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                          |  | (c)                                             |

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|                                                                                                                                                                                                                                                                                      |                                                                    |                                                                               |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on <b>4/25/86</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                    |                                                                               |                                                                                                                            |
| 22b. SIGNATURE<br>                                                                                                                                                                                |                                                                    | DEGREE                                                                        | 22c. DATE SIGNED<br><b>4-25-86</b>                                                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jose Fernandez, M.D.</b>                                                                                                                                                                                                                 |                                                                    | 22e. ADDRESS<br><b>St Agnes Hospital Caten Ave Balto, Md</b>                  |                                                                                                                            |

|                                                                                              |                             |                                                                     |                                                                                                                     |
|----------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                | 23b. DATE<br><b>4/29/86</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore Maryland</b>                                    |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc., 4107 Wilkens Ave.</b> |                             | 25. DATE RECD. BY REGISTRAR<br><b>APR 28 1986</b>                   | 25b. REGISTRAR'S SIGNATURE<br> |



00-03356

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10659  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                      |  |                                                                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE JULIE LAST FARDY                                                                                                                                                                                                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 9 86                                                                                                        |  | 2b. HOUR<br>7 P.M.                                                                                                                                          |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>White                                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 25, 1905                                                                                                         |  |
| 6. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>New York                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                                  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                                                                                                                                                                                                                                                                                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                                                        |  |                                                                                                                                                             |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br>Baltimore                                                                                                                             |  | 13c. CITY OR TOWN<br>Stevenson                                                                                                                              |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                       |  | 13e. STREET ADDRESS / ZIP CODE<br>1531 Greenspring Valley Rd. 21153                                                                                  |  |                                                                                                                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael Purtill                                                                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Stephens                                                                                  |  |                                                                                                                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>056-07-8628                                                                                                              |  | 17. INFORMANT<br>21022 ADDRESS Brooklandville, Md.<br>Sr. Margaret J. Purtill-11300 Falls Rd.                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) POSSIBLE GRAM NEGATIVE SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>DAYS |  |                                                                                                                                                      |  |                                                                                                                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>POSSIBLE CVA                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      |  |                                                                                                                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)                                                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |
| 22a. I certify that (I) (his hospital) attended the deceased from 4/8, 19 86 to 4/9, 19 86 that (I) (we) last saw the deceased alive on 4/9, 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (it) (we) did not view the body after death.                                                                                                                     |  |                                                                                                                                                      |  |                                                                                                                                                             |  |
| 22b. SIGNATURE<br>J. Mason MD                                                                                                                                                                                                                                                                                                                                                                                         |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>4/9/86                                                                                                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JULIE A. MASON                                                                                                                                                                                                                                                                                                                                                               |  | 22e. ADDRESS<br>MERCY HOSPITAL, 301 ST. PAUL PLACE BALTO.                                                                                            |  |                                                                                                                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>4-14-86                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. John's                                                                                                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Middle Village New York                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                      |  |                                                                                                                                                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br>1050 York Rd. Towson, Md. 21204                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 11 1986                                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson Pendell                                                                                                        |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



00-03794

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be retained with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10660  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                                                    |  |  |                                                                                                                                                             |  |  |                                                                                                                            |                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANCES</b>                                                                                                                                                                                                                                                                                                  |  |  | FIRST MIDDLE LAST<br><b>FARMER</b>                                                                                                 |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 9 86</b>                                                                                                        |  |  | 2b. HOUR<br><b>5<sup>10</sup> PM</b>                                                                                       |                                                             |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                |  |  | 4. RACE<br><b>Black</b>                                                                                                            |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10/26/26</b>                                                                                                       |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b>                                                                               |                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b>                                                             |                                                             |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                              |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                             |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                               |  |  | 13b. COUNTY                                                                                                                        |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Osburn Williams</b>                                                                                                                                                                                                                                                                                       |  |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br><b>Edna Williams</b>                                                                    |  |  | 16. STREET ADDRESS / ZIP CODE<br><b>513 N. Fulton Ave. 21213</b>                                                                                            |  |  |                                                                                                                            |                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-22-8795</b>                                                                                     |  |  | 17. INFORMANT ADDRESS<br><b>Regina Comegys 513 N. Fulton Ave. 21213</b>                                                                                     |  |  |                                                                                                                            |                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>URO SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____      |  |  |                                                                                                                                    |  |  |                                                                                                                                                             |  |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                    |  |  |                                                                                                                                    |  |  |                                                                                                                                                             |  |  |                                                                                                                            |                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                               |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4/9 1986</b>                                                                 |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |  |                                                                                                                            |                                                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                              |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |  |                                                                                                                            |                                                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/24</b> 19 <b>86</b> to <b>4/9</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/9</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |                                                                                                                                    |  |  |                                                                                                                                                             |  |  |                                                                                                                            |                                                             |  |
| 22b. SIGNATURE<br><b>J. A. Mason MD</b>                                                                                                                                                                                                                                                                                                                |  |  | DEGREE                                                                                                                             |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  | 22c. DATE SIGNED<br><b>4/9/86</b>                                                                                          |                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIE A. MASON</b>                                                                                                                                                                                                                                                                                         |  |  | 22e. ADDRESS<br><b>301 St. Paul Place, Mercy Hospital, Balto.</b>                                                                  |  |  |                                                                                                                                                             |  |  |                                                                                                                            |                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                             |  |  | 23b. DATE<br><b>4/15/86</b>                                                                                                        |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>                                                                                                |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                                            |                                                             |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Chas. A. Rice FSPA 1300 Eutaw Place</b>                                                                                                                                                                                                                                                                     |  |  |                                                                                                                                    |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>APR 16 1986</b>                                                                                                          |  |  |                                                                                                                            |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                                                    |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John D. ...</b>                                                                                                            |  |  |                                                                                                                            |                                                             |  |

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48780-00





00-03405

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1. FOR  
STATE  
REGISTRAR Constance Lee Farrell

REG. NO.

86 10661

|                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                      |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Constance I. Farrell</b>                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 12 1986</b> |                                                                                                                                                             |                                                                                      | 2b. HOUR<br><b>1:30 P.M.</b>                                                                                                               |                                                                                                                            |                                                                            |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 18 1900</b>                                                                                               |                                                             | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>86</b>                                                                                                              |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>                                                                                              |                                                                                                                            | IF UNDER 24 HRS<br>HOURS MIN.<br><b>13 P.M.</b>                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                    |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                        |                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                          |                                                                                                                            |                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Medical Center</b> |                                                             |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                       |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                          |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                   |                         | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                      |                                                             | 13c. CITY OR TOWN<br><b>Dundalk</b>                                                                                                                         |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |                                                                                                                            | 13e. STREET ADDRESS<br><b>Balto., Md.<br/>2904 Sollers Point Rd. 21222</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown Smedley</b>                                                                                                                                                                                                                                                                                                |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Sloat</b>                                                                               |                                                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                               |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                            |
| 16b. SOCIAL SECURITY NO.<br><b>219/28/5687</b>                                                                                                                                                                                                                                                                                                                  |                         | 17. INFORMANT<br>ADDRESS<br><b>Elizabeth A. McDermott (same as 13e.)</b>                                                                             |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                         |                                                                                                                                                      |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><b>possible retroabdominal process; seizure disorder, COPD</b>                                                                                                                                                              |                         |                                                                                                                                                      |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                             |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                         |                                                             | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 12 1986</b> to <b>April 12 1986</b> , that (I) (we) last saw the deceased alive on <b>April 12 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                  |                         |                                                                                                                                                      |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                            |
| 22b. SIGNATURE<br><b>Robert F. Committ</b>                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                      |                                                             | DEGREE<br><b>FSKMC</b>                                                                                                                                      |                                                                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                            | 22c. DATE SIGNED<br><b>4-12-86</b>                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert F. Committ</b>                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                      |                                                             | 22e. ADDRESS<br><b>FSKMC Eastern An, Balto, MD</b>                                                                                                          |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                   |                         | 23b. DATE<br><b>4/15/1986</b>                                                                                                                        |                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>                                                                                          |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland 21202</b>                                                             |                                                                                                                            |                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Walter Brooks Bradley Inc. Balto., Md. 21222</b>                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                      |                                                             | 25a. DATE RECEIVED BY REGISTRAR<br><b>APR 14 1986</b>                                                                                                       |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                      |                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>J. J. J. J. J.</b>                                                                                                         |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                            |

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00-05053

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 6 6 2  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                                    |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                           |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Annie Faulkner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 23, 1986</b>        |                                                                                                                                                            |  | 2b HOUR<br><b>2:59P M</b>                                                                      |  |                                                                                                                           |                                              |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4 RACE<br><b>Black</b>                                                                                                                       |                                                                    | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 18 1899</b>                                                                                                      |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>86 YRS</b>                                              |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>86 YRS</b>                                                              |                                              |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |                                                                    | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |  |                                                                                                                           |                                              |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                    |                                                                                                                                                            |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>             |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 13b COUNTY                                                                                                                                   |                                                                    | 13c CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE<br><b>1307 Winchester St. 21217</b>                                                         |                                              |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hubbard Dixon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Caster</b> |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                           |                                              |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16b SOCIAL SECURITY NO.<br><b>220-30-3891</b>                                                                                                |                                                                    | 17 INFORMANT ADDRESS<br><b>Bertha Watkins 1307 Winchester St. 21217</b>                                                                                    |  |                                                                                                |  |                                                                                                                           |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probable Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Longstanding Coronary Artery Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                       |  |                                                                                                                                              |                                                                    |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Congestive Heart Failure, Pulmonary Edema, Atrial Fibrillation</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                                                    |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                           |                                              |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |                                                                    |                                                                                                                                                            |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                     |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                             |                                                                    | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                |  |                                                                                                                           |                                              |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                 |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                                                    | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                |  |                                                                                                                           |                                              |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 23, 1986</b> , to <b>April 23, 1986</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 23, 1986</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) saw the body after death. |  |                                                                                                                                              |                                                                    |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                           |                                              |
| 22b SIGNATURE<br><b>Katherine Langenfelder</b> MD                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |                                                                    |                                                                                                                                                            |  | 22c DATE SIGNED<br><b>4/23/86</b>                                                              |  |                                                                                                                           |                                              |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Katherine Langenfelder, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                                                    |                                                                                                                                                            |  | 22e ADDRESS<br><b>c/o Maryland General Hospital</b>                                            |  |                                                                                                                           |                                              |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23b DATE<br><b>4-28-86</b>                                                                                                                   |                                                                    | 23c NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>                                                                                          |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Maryland</b>                          |  |                                                                                                                           |                                              |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Bailey-Douglass Funeral Home 1348 N. Calhoun St.</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |                                                                    |                                                                                                                                                            |  | 25a DATE REC'D. BY REGISTRAR<br><b>APR 29 1986</b>                                             |  | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                           |                                              |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must conduct an autopsy.

April 20, 1965  
Atlanta  
Atlanta City

Atlanta, Georgia 30303  
Atlanta, Georgia 30303

Atlanta, Georgia 30303

Atlanta, Georgia 30303

00-04156

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VIA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 6 6 3

|                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                        |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                     |  | 2a DATE OF DEATH MONTH DAY YEAR                                                                        |  | 2b HOUR                                                                                                                |                                              |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST                                                                                                                                                                                                                                          |  | 4-18-86                                                                                                |  | 6 PM                                                                                                                   |                                              |
| 3 SEX                                                                                                                                                                                                                                                                                      |  | 4 RACE                                                                                                 |  | 5 DATE OF BIRTH MONTH DAY YEAR                                                                                         |                                              |
| Fem.                                                                                                                                                                                                                                                                                       |  | CAU.                                                                                                   |  | 5 29 1897                                                                                                              |                                              |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                   |  | 7b CITIZEN OF WHAT COUNTRY?                                                                            |  | 8 AGE (IN YEARS LAST BIRTHDAY) YRS                                                                                     |                                              |
| Chicago                                                                                                                                                                                                                                                                                    |  | USA                                                                                                    |  | 88                                                                                                                     |                                              |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |                                              |
| BALTO                                                                                                                                                                                                                                                                                      |  | 340 STRATFORD RD.                                                                                      |  | BALTO. CITY MD                                                                                                         |                                              |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                               |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                       |  |                                                                                                                        |                                              |
| Housewife                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                        |                                              |
| 13a STATE                                                                                                                                                                                                                                                                                  |  | 13b COUNTY                                                                                             |  | 13c CITY OR TOWN                                                                                                       |                                              |
| MD.                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | BALTO                                                                                                                  |                                              |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| MATTHEW FLYNN                                                                                                                                                                                                                                                                              |  | HARRIET LEONARD.                                                                                       |  | 13e STREET ADDRESS / ZIP CODE                                                                                          |                                              |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                           |  | 16b SOCIAL SECURITY NO.                                                                                |  | 17 INFORMANT ADDRESS                                                                                                   |                                              |
| No                                                                                                                                                                                                                                                                                         |  | 361-4-5403                                                                                             |  | LAUREN FAULKNER 340 STRATFORD RD.                                                                                      |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BOWEL OBSTRUCTION</u>                                                                                                                                          |  |                                                                                                        |  |                                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                        | 2 WKS                                        |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DIVERTICULITIS</u>                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                        | 2 WKS                                        |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                        |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>EMPHYSEMA, PRIMARY BILIARY CIRRHOSIS</u>                                                                                                               |  |                                                                                                        |  |                                                                                                                        |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                  |                                              |
| -                                                                                                                                                                                                                                                                                          |  | -                                                                                                      |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-20-19, to 4-18-19, that (I) we last saw the deceased alive on 4-17-86, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death. |  | 22b. SIGNATURE                                                                                         |  | 22c. DATE SIGNED                                                                                                       |                                              |
| Christine L. Comerford, MD                                                                                                                                                                                                                                                                 |  | MD                                                                                                     |  | 4-21-86                                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                      |  | 22e. ADDRESS                                                                                           |  |                                                                                                                        |                                              |
| CHRISTINE L. COMERFORD, MD                                                                                                                                                                                                                                                                 |  | 5411 OLD FREDERICK RD BALTIMORE, MD                                                                    |  | 21229                                                                                                                  |                                              |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                   |  | 23b DATE                                                                                               |  | 23c NAME OF CEMETERY OR CREMATORY                                                                                      |                                              |
| Cremation                                                                                                                                                                                                                                                                                  |  | 4-21-86                                                                                                |  | Westview                                                                                                               |                                              |
| 23d LOCATION CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                     |  | 23e DATE REC'D BY REGISTRAR                                                                            |  | 23f REGISTRAR'S SIGNATURE                                                                                              |                                              |
| BALTO MD.                                                                                                                                                                                                                                                                                  |  | APR 21 1986                                                                                            |  | John Davidson-Napier                                                                                                   |                                              |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                          |  | 25a DATE REC'D BY REGISTRAR                                                                            |  | 25b REGISTRAR'S SIGNATURE                                                                                              |                                              |
| Frank Delaney 322 S. High St.                                                                                                                                                                                                                                                              |  | APR 21 1986                                                                                            |  | John Davidson-Napier                                                                                                   |                                              |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 0 6 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                       |                                                                                                                                                             |                                                                                              |                                                                                      |                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Goldie Faunt Leroy</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                       |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-11-86</b>                                        |                                                                                      | 2b. HOUR<br><b>5:30 P.M.</b>                                    |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br><b>B</b>                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 10 1894</b>                                                                                                      |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92 YRS</b>                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD                     |                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Balt.</b>                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unknown</b>           |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b>             |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                     |                                                                                                                                       |                                                                                                                                                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      |                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Emmanuel Faunt Leroy</b>                                                                                                                                                                                                                                                                                         |                                                                                                                                       |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lila Nullems</b>                         |                                                                                      |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br><b>231-10e5674</b>                                                                                                              |                                                                                              | 17. INFORMANT<br>ADDRESS<br><b>Raymond Thugs 1031 Witherspoon Rd 21212</b>           |                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                       |                                                                                                                                                             |                                                                                              |                                                                                      |                                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Septic</b>                                                                                                                                                                                                                |                                                                                                                                       |                                                                                                                                                             |                                                                                              |                                                                                      |                                                                 |
| 19a. DATE OF OPERATION<br><b>4-7-86</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Decubitus ulcer hip</b>                                                                              |                                                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                 |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                    |                                                                                                                                       | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |                                                                                              |                                                                                      |                                                                 |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                                                                                                                                                                                                             |                                                                                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                              |                                                                                      |                                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                     |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)                                                                                        |                                                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/11/86</b> to <b>4/11/86</b> , that (I) (we) last saw the deceased alive on <b>4/11/86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |                                                                                                                                       |                                                                                                                                                             |                                                                                              |                                                                                      |                                                                 |
| 22b. SIGNATURE<br><b>Dr. Lerdboon</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                       | DEGREE                                                                                                                                                      |                                                                                              | 22c. DATE SIGNED<br><b>4/11/86</b>                                                   |                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Lerdboon</b>                                                                                                                                                                                                                                                                                                  |                                                                                                                                       | 22e. ADDRESS<br><b>Lutheran Hospital</b>                                                                                                                    |                                                                                              |                                                                                      |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                    |                                                                                                                                       | 23b. DATE<br><b>4-17-86</b>                                                                                                                                 |                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Zion Cemetery</b>                     |                                                                 |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                       | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Bailey-Douglass Funeral Home 1348 N. Calhoun St.</b>                                                             |                                                                                              |                                                                                      |                                                                 |
| 25a. DATE REC'D. BY REGISTRAR<br><b>APR 17 1986</b>                                                                                                                                                                                                                                                                                                           |                                                                                                                                       | 25b. REGISTRAR'S SIGNATURE<br><b>J. L. Davidson</b>                                                                                                         |                                                                                              |                                                                                      |                                                                 |

SECRET DOCUMENT

10/1/50

10/1/50

10/1/50

10/1/50

10/1/50





00-02651

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 2 should be filed with the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 444-3300.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |  | 86 10665                                                                                                                                                   |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                |  | REG NO.                                                                                                                                                    |  |                                                                                                                         |  |
| 1 DECEASED NAME (TYE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CATHERINE E. FELTER</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>04-03-86</b>                                                                                                        |  | 2b. HOUR<br><b>310aM</b>                                                                                                |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                            |  | 4 RACE<br><b>White</b>                                                                                                                         |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 05 13</b>                                                                                                         |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>72</b>                                                             |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>                                                                                                                                                                                                                                                                                                                |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                      |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                                         |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL 21218</b> |  | 12a USUAL OCCUPATION (TYE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                                            |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                        |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                          |  | 13b COUNTY<br><b>--</b>                                                                                                                        |  | 13c CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>(unknown)</b>                                                                                                                                                                                                                                                                                                                            |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>(unknown) Wood</b>                                                                             |  | 13e STREET ADDRESS / ZIP CODE<br><b>1134 Falls Hill Drive 21211</b>                                                                                        |  |                                                                                                                         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                         |  | 16b SOCIAL SECURITY NO<br><b>213-20-3281</b>                                                                                                   |  | 17 INFORMANT ADDRESS<br><b>Maureen Ruby 3720 Miller Statton Rd. 21102</b>                                                                                  |  |                                                                                                                         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MASSIVE myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                     |  |                                                                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 hours</b>                                                                                            |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  |                                                                                                                                                            |  |                                                                                                                         |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                            |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                             |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 2nd</b> , 19 <b>86</b> , to <b>April 3rd</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>April 3rd</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                |  |                                                                                                                                                            |  |                                                                                                                         |  |
| 22b SIGNATURE<br><b>Diego Ramos MD</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                |  | DEGREE<br><b>MD</b>                                                                                                                                        |  | 22c. DATE SIGNED<br><b>4-3-86</b>                                                                                       |  |
| 22d PHYSICIAN'S NAME (TYE OR PRINT)<br><b>DIEGO RAMOS, M.D.</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  | 22e ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                              |  |                                                                                                                         |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>4/5/86</b>                                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem. Gdns Timonium</b>                                                                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Maryland</b>                                                              |  |
| 24 FUNERAL DIRECTOR NAME ADDRESS<br><b>A. Alan Seitz, Jr. 3818 Roland Avenue 21211</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                |  | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE<br><b>APR 04 1986 Julia Davidson-Hendall</b>                                                        |  |                                                                                                                         |  |



00-05431

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10666  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Baker Felts, III                                                                                                                                                                                                                                                                                               |                                                                                                                             |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>04 27 86                                                 |                                                                                | 2b. HOUR<br>5:53 P                                                                                                         |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                             | 4. RACE<br>Cauc.                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 29 32                                                                                                               |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Balto                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Steel Worker                |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel                                                                           |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                    |                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                     | 13b. COUNTY<br>Baltimore                                                                                                    | 13c. CITY OR TOWN<br>Middle River                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>9708 Matzon Road 21220                       |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Baker Felts, Jr.                                                                                                                                                                                                                                                                                            |                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mildred E. Gray                                                                                            |                                                                                                 |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                     |                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>219-28-6439                                                                                                                     |                                                                                                 | 17. INFORMANT<br>ADDRESS<br>Patricia A. Felts Same as 13e                      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio pulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Lymphosarcoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                           |                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                               |                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |                                                                                                                             |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br>C. Pope                                                                                                                                                                                                                                                                                                                                  |                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                                 | 22c. DATE SIGNED<br>4/27/86                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. Pope                                                                                                                                                                                                                                                                                                           |                                                                                                                             | 22e. ADDRESS<br>Sinai Hospital                                                                                                                              |                                                                                                 |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                        |                                                                                                                             | 23b. DATE<br>5/1/1986                                                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill                                                |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>White Marsh Maryland                                                         |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222                                                                                                                                                                                                                                                           |                                                                                                                             |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>MAY 2 1986                                                     |                                                                                |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                             |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br>John A. ...                                                       |                                                                                |                                                                                                                            |

BP

Page 40 of 40

*[Faint, mostly illegible text follows, appearing to be a multi-paragraph document or report.]*

00-04144

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10667

|                                                                                                                                    |  |         |                   |                                                                                                                                                                                                                                                                                                                                                                |  |                         |  |                                                                                                                                                          |                |                  |  |                                                                                                                                            |  |           |  |
|------------------------------------------------------------------------------------------------------------------------------------|--|---------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                |  |         | FIRST MIDDLE LAST |                                                                                                                                                                                                                                                                                                                                                                |  | 2a. DATE KNOWN OF DEATH |  |                                                                                                                                                          | MONTH DAY YEAR |                  |  | 2b. HOUR                                                                                                                                   |  |           |  |
| VICTOR GIGIO FENNER                                                                                                                |  |         |                   |                                                                                                                                                                                                                                                                                                                                                                |  | 4 17 1986               |  |                                                                                                                                                          | 4 17 1986      |                  |  | 10:27 A M                                                                                                                                  |  |           |  |
| 3. SEX                                                                                                                             |  | 4. RACE |                   | 5. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                               |  | 6. AGE (IN YEARS)       |  | IF UNDER 1 YR.                                                                                                                                           |                | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD                                                                                                                   |  | 7d. HOUR  |  |
| MALE                                                                                                                               |  | BLACK   |                   | 1 7 64                                                                                                                                                                                                                                                                                                                                                         |  | 22 YRS.                 |  | MONTHS DAYS                                                                                                                                              |                | HOURS MIN.       |  | 4 17 1986                                                                                                                                  |  | 10:27 A M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                          |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                   |  |                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |  |           |  |
| MD                                                                                                                                 |  |         |                   | USA                                                                                                                                                                                                                                                                                                                                                            |  |                         |  |                                                                                                                                                          |                |                  |  | Baltimore City MD                                                                                                                          |  |           |  |
| 10. CITY OR TOWN OF DEATH                                                                                                          |  |         |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                                                                                                                                                                                                                                                                                       |  |                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK)                                                                                                                     |                |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                          |  |           |  |
| Baltimore                                                                                                                          |  |         |                   | Johns Hopkins Hospital                                                                                                                                                                                                                                                                                                                                         |  |                         |  | UNEMPLOYED                                                                                                                                               |                |                  |  |                                                                                                                                            |  |           |  |
| 13a. STATE                                                                                                                         |  |         |                   | 13b. COUNTY                                                                                                                                                                                                                                                                                                                                                    |  |                         |  | 13c. CITY OR TOWN                                                                                                                                        |                |                  |  | 13d. INSIDE CITY LIMITS?                                                                                                                   |  |           |  |
| MD                                                                                                                                 |  |         |                   |                                                                                                                                                                                                                                                                                                                                                                |  |                         |  | BALTIMORE                                                                                                                                                |                |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |           |  |
| 14. FATHER'S NAME                                                                                                                  |  |         |                   | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                       |  |                         |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                             |                |                  |  | 16b. SOCIAL SECURITY NO.                                                                                                                   |  |           |  |
| CLAYTON                                                                                                                            |  |         |                   | FENNER                                                                                                                                                                                                                                                                                                                                                         |  |                         |  | LORRAINE                                                                                                                                                 |                |                  |  | HARRISON                                                                                                                                   |  |           |  |
| 17. INFORMANT                                                                                                                      |  |         |                   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                      |  |                         |  | 19a. DATE OF OPERATION                                                                                                                                   |                |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                          |  |           |  |
| CLAYTON/LORRAINE FENNER 2103 HOMEWOOD AVE.                                                                                         |  |         |                   | PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hanging</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                               |  |                         |  |                                                                                                                                                          |                |                  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                        |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |         |                   |                                                                                                                                                                                                                                                                                                                                                                |  |                         |  |                                                                                                                                                          |                |                  |  |                                                                                                                                            |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH     |  |         |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 4-16- 1986                                                                                                                                                                                                                                                                                           |  |                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                |                  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK |  |           |  |
|                                                                                                                                    |  |         |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>building                                                                                                                                                                                                                                                                                        |  |                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Balto. City Jail, Balto. MD                                                                         |                |                  |  |                                                                                                                                            |  |           |  |
| 22a. I certify that I took charge of the remains described above, held on                                                          |  |         |                   | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |                                                                                                                                                          |                |                  |  |                                                                                                                                            |  |           |  |
| ACTUAL SIGNATURE                                                                                                                   |  |         |                   | TITLE (SPECIFY)                                                                                                                                                                                                                                                                                                                                                |  |                         |  | DATE SIGNED                                                                                                                                              |                |                  |  |                                                                                                                                            |  |           |  |
|                                                                                                                                    |  |         |                   | M.D. Assistant MEDICAL EXAMINER                                                                                                                                                                                                                                                                                                                                |  |                         |  | 4-18-86                                                                                                                                                  |                |                  |  |                                                                                                                                            |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                    |  |         |                   | ADDRESS                                                                                                                                                                                                                                                                                                                                                        |  |                         |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                |                |                  |  | 23b. DATE                                                                                                                                  |  |           |  |
| Ann M. Dixon, M.D.                                                                                                                 |  |         |                   | 111 Penn St., Balto., MD 21201                                                                                                                                                                                                                                                                                                                                 |  |                         |  | BURIAL                                                                                                                                                   |                |                  |  | 4-22-86                                                                                                                                    |  |           |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                          |  |         |                   | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                  |  |                         |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |                |                  |  | 25c. LOCATION CITY OR TOWN COUNTY STATE                                                                                                    |  |           |  |
| WM. C. MARCH FUNERAL HOME 1101 E. NORTH AVE.                                                                                       |  |         |                   | APR 21 1986                                                                                                                                                                                                                                                                                                                                                    |  |                         |  |                                                                                                                                                          |                |                  |  | BALTIMORE MD                                                                                                                               |  |           |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHWH - 17  
(VR A15 ME (15))



00-03025

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                     |  |              |  |                                                                                                                               |  |                                                                               |  |                                                                                                                                                             |  | REG. NO. 10668                                                                                       |  |                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>LUTHER J. FIELDS Sr.                                                                                                                                                                                                                                                                                                                                                               |  |              |  |                                                                                                                               |  |                                                                               |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>4 5 19 86 |  | 2b. HOUR<br>M<br>7:30 A.M.                                |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>B |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 7 33                                                                                 |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>52 YRS.        |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>4 5 19 86                                                                                                     |  | 7d. HOUR<br>M<br>7:30 A.M.                                                                           |  |                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.                                                                                                                                                                                                                                                                                                                                                                                           |  |              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                        |  |                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                                                                                                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                      |  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>745 Carroll St. |  |                                                                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A                                                                                        |  |                                                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                         |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                      |  |              |  | 13b. COUNTY                                                                                                                   |  | 13c. CITY OR TOWN<br>BALTIMORE                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br>745 CAREY STREET                                                              |  |                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALBERT H. FIELDS                                                                                                                                                                                                                                                                                                                                                                                  |  |              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DAISY WILLIAMS                                                               |  |                                                                               |  |                                                                                                                                                             |  |                                                                                                      |  |                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>MO                                                                                                                                                                                                                                                                                                                                                                 |  |              |  | 16b. SOCIAL SECURITY NO.<br>219-32-5198                                                                                       |  | 17. INFORMANT ADDRESS<br>NAOMI WRIGHT 34 S. CATHERINE ST.                     |  |                                                                                                                                                             |  |                                                                                                      |  |                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                               |  |              |  |                                                                                                                               |  |                                                                               |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                         |  |                                                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.                                                                                                                                                                                                                                                                                                           |  |              |  |                                                                                                                               |  |                                                                               |  |                                                                                                                                                             |  |                                                                                                      |  |                                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                      |  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                             |  |                                                                               |  |                                                                                                                                                             |  | 20. AUTOPSY?<br>Head Only<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  |                                                           |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                                                                                                             |  |                                                                                                      |  |                                                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |  |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                                                             |  |                                                                                                      |  |                                                           |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |              |  |                                                                                                                               |  |                                                                               |  |                                                                                                                                                             |  |                                                                                                      |  |                                                           |  |
| ACTUAL SIGNATURE<br><i>John E. Smialek</i>                                                                                                                                                                                                                                                                                                                                                                                                  |  |              |  | TITLE (SPECIFY)<br>M.D. Chief                                                                                                 |  |                                                                               |  | DATE SIGNED<br>4-5-86                                                                                                                                       |  |                                                                                                      |  |                                                           |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John E. Smialek, M.D.                                                                                                                                                                                                                                                                                                                                                                                 |  |              |  | ADDRESS<br>111 Penn St., Balt., MD, 21201                                                                                     |  |                                                                               |  |                                                                                                                                                             |  |                                                                                                      |  |                                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                        |  |              |  | 23b. DATE<br>4-10-86                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART                            |  |                                                                                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE COUNTY MARYLAND                              |  |                                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM.C.MARCH F/H INC.                                                                                                                                                                                                                                                                                                                                                                                         |  |              |  | ADDRESS<br>1101 E. NORTH AVE.                                                                                                 |  |                                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 09 1986                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><i>John E. Smialek</i>                                                 |  |                                                           |  |

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(VR A15 ME (5))

NO. 100-111111



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 6 6 9

REG. NO.

|                                                                                           |                                                                                                                                               |                                                                                                                                                            |                                                                                   |                                                                                        |                                                       |
|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Willis (WILLIAM) Fields</b> |                                                                                                                                               |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 30, 1986</b>                       |                                                                                        | 2b HOUR<br><b>6:40P<sup>M</sup></b>                   |
| 3 SEX<br><b>M</b>                                                                         | 4 RACE<br><b>W</b>                                                                                                                            | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8/20/1912</b>                                                                                                      |                                                                                   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS                                        |                                                       |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>KENTUCKY</b>                               | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                        |                                                       |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PLUMBER</b> |                                                                                        | 12b KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCT.</b> |
| 13a STATE<br><b>MD</b>                                                                    |                                                                                                                                               |                                                                                                                                                            | 13b COUNTY<br><b>BALTO.</b>                                                       | 13c CITY OR TOWN<br><b>BALTO.</b>                                                      |                                                       |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT FIELDS</b>                             |                                                                                                                                               |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MINNIE SUBLET</b>              |                                                                                        |                                                       |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>          |                                                                                                                                               | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-01-4127</b>                                                                               |                                                                                   | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Margaret P. Fields - 2916 E. Monument St. 21205</b> |                                                       |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Myocardial Infarction**

DO TO, OR AS A CONSEQUENCE OF  
(b) **Cerebral Vascular Accident**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  
DO TO, OR AS A CONSEQUENCE OF  
(c) **Atherosclerotic Vascular Disease**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  
**Diabetes Mellitus, Parkinson's Disease**

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                      |                                                                               |                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                         | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                      | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                        | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                     | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                                           |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                 | 21e PLACE OF INJURY<br>(ATHOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                 | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                           |
| 22a I certify that (X) (this hospital) attended the deceased from <b>April 15, 1986</b> to <b>April 30, 1986</b> that (X) (we) last saw the deceased alive on <b>April 30, 1986</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |                                                                                                                                                      |                                                                               |                                                                                                                           |
| 22b SIGNATURE<br><b>Timothy J. Low</b>                                                                                                                                                                                                                                                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED<br><b>4/30/86</b>                                             |                                                                                                                           |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TIMOTHY J. LOW</b>                                                                                                                                                                                                                                                                                 | 22e ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                  |                                                                               |                                                                                                                           |

|                                                                         |                           |                                                                |                                                                 |
|-------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------|-----------------------------------------------------------------|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>            | 23b DATE<br><b>5/5/86</b> | 23c NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER CEM.</b> | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO., MD.</b> |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Stanley G. Lee - 7527 Harford Rd.</b> |                           | 25a DATE REC'D. BY REGISTRAR<br><b>MAY 2 1986</b>              |                                                                 |

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10670  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                        |                                                                                                                                           |                                                                                                                                                             |                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Walter 3 Fike Sr.                                                                                                                                                                                                                                                                                     |  |                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4/30/86                                                                                            |                                                                                                                                                             | 2b. HOUR<br>9:39 AM |  |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br>Cauc                                                        |                                                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1/1/07                                                                                                                |                     |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                    |                                                                                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                            |  |                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key med center |                                                                                                                                                             |                     |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br>Balto.                                                  |                                                                                                                                           | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ezra Fike                                                                                                                                                                                                                                                                                                               |  |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Myra                                                                                     |                                                                                                                                                             |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>yes WWII                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>215 30 7083                                |                                                                                                                                           | 17. INFORMANT<br>Marie Fike 21 Ridgemoor Road 21221                                                                                                         |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiopulmonary event</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                        |                                                                                                                                           |                                                                                                                                                             |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                               |  |                                                                        |                                                                                                                                           |                                                                                                                                                             |                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                           | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/30</u> 19 <u>86</u> to <u>4/30</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/30</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.        |  |                                                                        |                                                                                                                                           |                                                                                                                                                             |                     |  |
| 22b. SIGNATURE<br>W. Willes, M.D.                                                                                                                                                                                                                                                                                                                                 |  |                                                                        |                                                                                                                                           | 22c. DATE SIGNED<br>4/30/86                                                                                                                                 |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Willes                                                                                                                                                                                                                                                                                                                   |  |                                                                        |                                                                                                                                           | 22e. ADDRESS<br>Fslumc                                                                                                                                      |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>5/3/86                                                    |                                                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Cemetery                                                                                                   |                     |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Middle River                                                                                                                                                                                                                                                                                                                     |  | 23e. COUNTY<br>Balto.                                                  |                                                                                                                                           | 23f. STATE<br>Maryland                                                                                                                                      |                     |  |
| 24. FUNERAL DIRECTOR<br>Connelly Funeral Home 300 Mace Ave. 21221                                                                                                                                                                                                                                                                                                 |  |                                                                        |                                                                                                                                           | 25a. DATE REC'D. BY REGISTRAR<br>MAY 2 1986                                                                                                                 |                     |  |
|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                        |                                                                                                                                           | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |                     |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)



-03583

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                      |  |                                                                                                                                    |  |                                                                                                                                                         |  |                                                                                                                                                             |  | REG. NO. 0671                                                                    |  |                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|----------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                      |  |                                                                                                                                    |  |                                                                                                                                                         |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH                                                          |  | 2b. HOUR       |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JAMES R. FINN                                                                                                                                                                                                                                                                                                                                                                      |  |                      |  |                                                                                                                                    |  |                                                                                                                                                         |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 4-13-86  |  | 2b. HOUR 4:35P |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>CAUCASIAN |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>09 13 55                                                                                        |  | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>30 YRS.                                                                                     |  | 7c. DATE PRONOUNCED DEAD<br>4-13-86                                                                                                                         |  | 7d. HOUR 4:35P                                                                   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                    |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                |  |                                                                                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                        |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital STU |  |                                                                                                                                                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK) (WORKING LIFE)<br>LABORER                                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CARPET                                      |  |                |  |
| 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 113 BLED SOE RD. 21220                                                                                                                                                                                                                            |  |                      |  |                                                                                                                                    |  |                                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                  |  |                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JAMES J. FINN                                                                                                                                                                                                                                                                                                                                                                                     |  |                      |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MYRNA HAMAN                                                                                               |  |                                                                                                                                                             |  |                                                                                  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                 |  |                      |  |                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>217625249                                                                                                                   |  | 17. INFORMANT ADDRESS<br>MYRNA MOROSKO 3120 NOVA SCOTIA RD.                                                                                                 |  |                                                                                  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cranio-cerebral trauma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                 |  |                      |  |                                                                                                                                    |  |                                                                                                                                                         |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |                      |  |                                                                                                                                    |  |                                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                  |  |                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                  |  |                                                                                                                                                         |  |                                                                                                                                                             |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                    |  |                      |  | 21b. TIME OF INJURY<br>8:40P.M. 4-12-86                                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)<br>driver of motorcycle which struck medial-over-turned ejecting subject. |  |                                                                                                                                                             |  |                                                                                  |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                               |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>hwy.                                                                |  | 21f. LOCATION (CITY OR TOWN) STREET CITY OR TOWN COUNTY STATE<br>Eastern Blvd & 1/10 mile E. of Essex, Md. BALTO. BALTO. MD.                            |  |                                                                                                                                                             |  |                                                                                  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |                                                                                                                                    |  |                                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                  |  |                |  |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i>                                                                                                                                                                                                                                                                                                                                                                                              |  |                      |  |                                                                                                                                    |  | TITLE (SPECIFY) M.D. Assistant                                                                                                                          |  | MEDICAL EXAMINER                                                                                                                                            |  | DATE SIGNED 4--14-86                                                             |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                |  |                      |  |                                                                                                                                    |  | ADDRESS 111 Penn Street                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                |  |                      |  | 23b. DATE<br>04/16/86                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLLY HILLS                                                                                                       |  | 23d. LOCATION (CITY OR TOWN) COUNTY STATE<br>BALTO. BALTO. MD.                                                                                              |  |                                                                                  |  |                |  |
| 24. FUNERAL DIRECTOR <i>John Chesapeake</i>                                                                                                                                                                                                                                                                                                                                                                                              |  |                      |  |                                                                                                                                    |  | ADDRESS 1211 Chesapeake                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 15 1986                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rendell</i>                          |  |                |  |

Handwritten text, possibly a list or notes, with a circular stamp or seal in the center.

Handwritten text, possibly a signature or a date, located below the first section.

0-04571

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the back, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 also 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical certificate must be completed on Form 100-101.

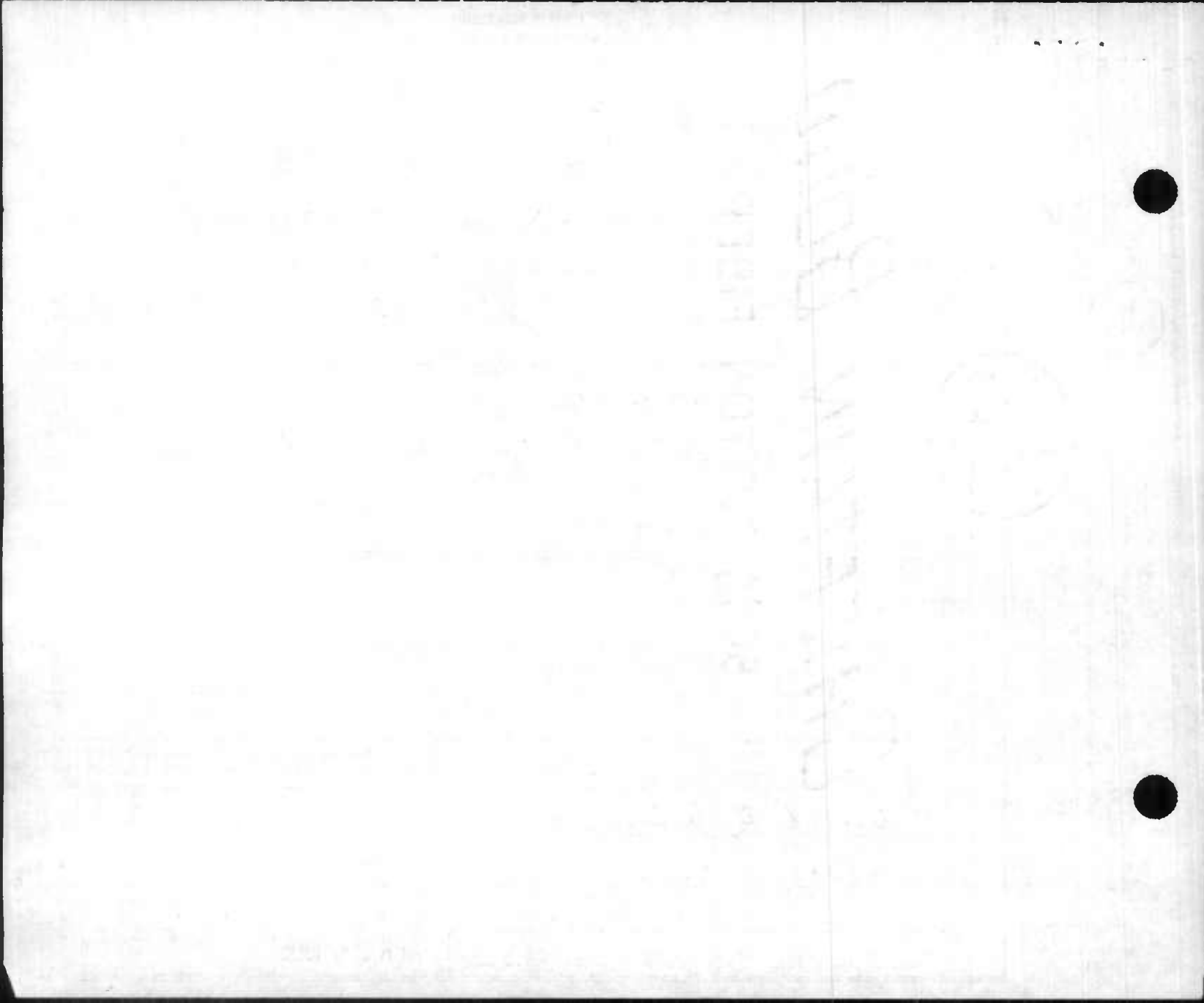
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO.

10672

|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                            |  | 2a. DATE OF DEATH                                                                                      |  | MONTH DAY YEAR                                                                                                                                           |  | 2b. HOUR                                                            |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                  |  | FIRST MIDDLE LAST                                                                                      |  | 4-22-86                                                                                                                                                  |  | 4:22 P.M.                                                           |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                            |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                                              |
| F                                                                                                                                                                                                                                                                                                                                 |  | White                                                                                                  |  | 4 3 1893                                                                                                                                                 |  | 93                                                                  |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                              |
| Italy                                                                                                                                                                                                                                                                                                                             |  | United States                                                                                          |  |                                                                                                                                                          |  | Baltimore City MD.                                                  |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                              |
| Balto. City                                                                                                                                                                                                                                                                                                                       |  | St. Joseph's Hospital                                                                                  |  | Home maker                                                                                                                                               |  |                                                                     |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |                                              |
| MD                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | Balto.                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 13e. STREET ADDRESS / ZIP CODE                                                                                                                           |  |                                                                     |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                 |  | FIRST MIDDLE LAST                                                                                      |  | 6110 Ridgeview Ave                                                                                                                                       |  | 21206 Ave                                                           |                                              |
| Joseph Serra                                                                                                                                                                                                                                                                                                                      |  | Theresa Serra                                                                                          |  |                                                                                                                                                          |  |                                                                     |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                             |                                              |
| No                                                                                                                                                                                                                                                                                                                                |  | 218-12-472                                                                                             |  | Rita Christensen                                                                                                                                         |  | 6110 Ridgeview Ave. 21206                                           |                                              |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardio-vascular disease</i>                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                              |
|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                           |  |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                   |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                     |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f. LOCATION STREET                                                                                                                                     |  | CITY OR TOWN COUNTY STATE                                           |                                              |
|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | DEGREE                                                                                                                                                   |  | 22c. DATE SIGNED                                                    |                                              |
| Natividad D. de Leon, M.D.                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 4/22/1986                                                           |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | 22e. ADDRESS                                                                                                                                             |  |                                                                     |                                              |
| NATIVIDAD D. DE LEON                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 610 ST. JOSEPH HOSPITAL, TOWSON, MD. 21204                                                                                                               |  |                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                         |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                                              |
| Burial                                                                                                                                                                                                                                                                                                                            |  | 4-25-86                                                                                                |  | Holy Redeemer Cem.                                                                                                                                       |  | Balto. Md.                                                          |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                          |                                              |
| John C. Miller Inc. 6415 Belair Rd. 21206                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | APR 24 1986                                                                                                                                              |  |                                                                     |                                              |

BP





00-05307

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 6 7 3  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 1. DECEASED NAME FIRST MIDDLE LAST<br><b>Mamie Alda FIORIO</b>                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 25, 1986</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 2b. HOUR<br><b>9:35<sup>A</sup> M</b>                                                        |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4 RACE<br><b>White</b>                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 23, 1889</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>96</b>                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                              |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>                                                                                                                                                                                                                                                                                                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                            |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>John</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br><b>Maria</b>                                                                                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>216-22-9465</b>                                               |  |
| 17. INFORMANT<br><b>Patricia E. Martin</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 18. ADDRESS<br><b>28 Woodglen Avenue Niles, Ohio 44446</b>                                                                                 |  | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Gastro-intestinal bleed; Severe Senile Dementia</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  | 20a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                                                                       |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                                      |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 10</b> , 19 <b>86</b> , to <b>April 25</b> , 19 <b>86</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 25</b> , 19 <b>86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (not) view the body after death. |  |                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                              |  |
| 22b. SIGNATURE<br><b>Robert E. Roby</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            |  | DEGREE<br><b>M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22c. DATE SIGNED<br><b>4/25/86</b>                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert E. Roby, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            |  | 22e. ADDRESS<br><b>/co Maryland General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>4-28-86</b>                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery Hagerstown, Washington, Md.</b>                                                                                                                                                                                                                                                                                                                                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                      |  |
| 24. FUNERAL DIRECTOR NAME<br><b>A.K. Coffman Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 1 1986</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson</b>                                          |  |

10-65304

also

Sept. 27, 1963

U.S.A.

X

Seamstress

21001  
Vas North Street

X

Salisbury

Northampton

Haris Priest

John

210-22-042 Haris M. Haris  
on a street Avenue  
Main, N.Y. 10040

A.R. Coffin Funeral Home, Inc.  
Beverly Hills, Ca.  
210-22-042  
Last known Cemetery location, Main St, No

0-04303

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 17 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 6 7 4  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                      |                                                                                                                                                             |                                                                                                               |                                                                                                    |                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALBERT A. FISCHER</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 19 86</b>                                                         |                                                                                                    | 2b. HOUR<br><b>2420M</b>                                            |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br><b>CAUCASIAN</b>                                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 12 21</b>                                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b><br>YRS.                                                          | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                       |                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                              |                                                                                                    |                                                                     |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>                            |                                                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Maintenance</b>             |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                      | 13b. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br><b>1639 Covington St / 21230</b>                                 |                                                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward A. Fischer</b>                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma M. Fischer</b>                                                                                     |                                                                                                               |                                                                                                    |                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES GIVE WAR OR DATES)<br><b>UNKNOWN</b> <b>W.W.2</b>                                                                                                                                                                                                                                                                                   |                                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>214128404</b>                                                                                                                | 17. INFORMANT<br>ADDRESS<br><b>3001 S. HANOVER ST BALTIMORE MD 21230</b>                                      |                                                                                                    |                                                                     |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO Pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Acute respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of (R) lung</b> |                                                                                                                                                      |                                                                                                                                                             |                                                                                                               |                                                                                                    |                                                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a<br><b>Pneumonia (R) lung</b>                                                                                                                                                                                                                                                  |                                                                                                                                                      |                                                                                                                                                             |                                                                                                               |                                                                                                    |                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                               | 20a. AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |                                                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                          |                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4 11 86</b><br>P.M. 19                                                                                |                                                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                      |                                                                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                     |                                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                  |                                                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/30</b> 19 <b>86</b> to <b>4/19</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/19</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.                                                             |                                                                                                                                                      |                                                                                                                                                             |                                                                                                               |                                                                                                    |                                                                     |
| 22b. SIGNATURE<br><b>John D. Milto</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                      | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                                               | 22c. DATE SIGNED<br><b>4/19/86</b>                                                                 |                                                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN D. MILTO</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                      | 22e. ADDRESS<br><b>3001 S. HANOVER ST BALTIMORE MD 21230</b>                                                                                                |                                                                                                               |                                                                                                    |                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                      | 23b. DATE<br><b>4/20/1986</b>                                                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Proc. Crem.</b>                                             |                                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home, 130 E. Fort Ave.</b>                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                      |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 22 1986</b>                                                           |                                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                  |

BP

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0-05660

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10675  
REG. NO.

|                                                                                                                      |  |                                                                                                                                              |                                                                  |                                                                                                                                                             |                            |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Carlyn</u> MIDDLE <u>S.</u> LAST <u>Fisher</u>                       |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH <u>4</u> DAY <u>30</u> YEAR <u>86</u> |                                                                                                                                                             | 2b. HOUR<br><u>11</u> P.M. |                                                                                                 |  |
| 3. SEX<br><u>Female</u>                                                                                              |  | 4. RACE<br><u>Caucasian</u>                                                                                                                  |                                                                  | 5. DATE OF BIRTH<br>MONTH <u>7</u> DAY <u>12</u> YEAR <u>97</u>                                                                                             |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>88</u> YRS                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                                                                                                  |                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Sinai Hospital of Balto.</u> |                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>TEACHER</u>                                                                          |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>EDUCATION</u>                                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>MD</u> |  | 13b. COUNTY<br><u>Baltimore</u>                                                                                                              |                                                                  | 13c. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                       |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <u>LEOPOLD</u> MIDDLE <u></u> LAST <u>STERN</u>                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>ROSE</u> MIDDLE <u></u> LAST <u>HARTSBERG</u>                                                           |                                                                  | 13e. STREET ADDRESS / ZIP CODE<br><u>7111 Park Hts. Ave. 21215</u>                                                                                          |                            | APT. <u>908</u>                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>                                    |  | 16b. SOCIAL SECURITY NO.<br><u>213-26-6087</u>                                                                                               |                                                                  | 17. INFORMANT<br><u>ROBERT S. FISHER</u>                                                                                                                    |                            | APT. <u>908</u>                                                                                 |  |
|                                                                                                                      |  |                                                                                                                                              |                                                                  | <u>7111 PARK HTS. AVE.</u>                                                                                                                                  |                            | <u>BALTO., MD 21215</u>                                                                         |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) cardiac arrestAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHimmediate

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) ARDS → progressive hypoxia24 hrs

DUE TO, OR AS A CONSEQUENCE OF

(c) hypotension, MI, pneumonia40 hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                   |  |                                                                               |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> 19 <u>86</u> to <u>4/30</u> 19 <u>86</u> , that (I) (we) last<br>saw the deceased alive on <u>4/30</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |                                                                   |  |                                                                               |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><u>Richard P. Allan</u>                                                                                                                                                                                                                                                                                                                        |  |                                                                   |  | DEGREE<br><u>MD</u>                                                           |  | 22c. DATE SIGNED<br><u>4/30/86</u>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Richard P. Allan</u>                                                                                                                                                                                                                                                                                                 |  |                                                                   |  | 22e. ADDRESS<br><u>Sinai Hospital of Baltimore/21215</u>                      |  |                                                                                                                               |  |

|                                                                                                                             |  |                                 |  |                                                          |  |                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------|--|---------------------------------|--|----------------------------------------------------------|--|----------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>BURIAL</u>                                                                  |  | 23b. DATE<br><u>MAY 2, 1986</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>OHED SHALOM</u> |  | 23d. LOCATION<br><u>BALTIMORE</u> COUNTY <u>MARYLAND</u> STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>SOL LEVINSON &amp; BROS., INC.</u><br>ADDRESS <u>6010 REISTERSTOWN RD. BALTO., MD 21215</u> |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 6 1986</u>       |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner, it should be detached for use as the burial-transit permit. Then please forward it, along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must file a report with the State Dept. of Health and Mental Hygiene.



00-04574

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8610676  
REG. NO.

|                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                         |  |                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                            |  | 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Irene Fisher</i>                                                                                                                                                                                                                                                                                                      |  | 2a DATE OF DEATH MONTH DAY YEAR<br><i>April 18 1986</i>                                                                                                 |  | 2b HOUR<br><i>18:21 M</i>                                                                                               |  |
| 3 SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                            |  | 4 RACE<br><i>Black</i>                                                                                                                                                                                                                                                                                                                                                           |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><i>6-12-13</i>                                                                                                        |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><i>72</i>                                                 |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>                                                                                                                                                                                                                                                       |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                                                                                                                                                                                                                                                     |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City MD</i>                                                         |  |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SINAI HOSP.</i>                                                                                                                                                                                                                                                     |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>                                                                        |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                        |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN<br><i>Maryland Balto.</i>                                                                                                                                                                   |  | 13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                      |  | 13c STREET ADDRESS ZIP CODE<br><i>3415 Cederdale Ave. 21215</i>                                                                                         |  |                                                                                                                         |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><i>Sam Fisher</i>                                                                                                                                                                                                                                                           |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Mamie Kennedy</i>                                                                                                                                                                                                                                                                                                                |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>NO.</i>                                                                          |  | 16b SOCIAL SECURITY NO.<br><i>214-20-5301</i>                                                                           |  |
| 17 INFORMANT ADDRESS<br><i>Mr. James Fisher 2036 E. Hoffman St. 21213</i>                                                                                                                                                                                                                                         |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>ACUTE Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i></i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>≤ 24 hrs</i><br><i>≤ 24 hrs</i>                                                                      |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                         |  |                                                                                                                         |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                 |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                                                                                                                                                                                                                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                          |  | 21e PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)                                                                                                                                                                                                                                                                                                                  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) lost <i>saw</i> the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                         |  |                                                                                                                         |  |
| 22b SIGNATURE<br><i>MARCIA V. Brock</i>                                                                                                                                                                                                                                                                           |  | DEGREE<br><i>MD</i>                                                                                                                                                                                                                                                                                                                                                              |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> HOUSE STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c DATE SIGNED<br><i>4/18/86</i>                                                                                       |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MARCIA V. Brock MD</i>                                                                                                                                                                                                                                                 |  | 22e ADDRESS<br><i>Sinai Hospital of Baltimore</i>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                         |  |                                                                                                                         |  |
| 23a BURIAL, CREMATION, REMOVAL (RECEIPT)<br><i>BURIAL</i>                                                                                                                                                                                                                                                         |  | 23b DATE<br><i>4-23-86</i>                                                                                                                                                                                                                                                                                                                                                       |  | 23c NAME OF CEMETERY OR CREMATORY<br><i>Mt. Auburn Cem.</i>                                                                                             |  | 23d LOCATION CITY TOWN COUNTY STATE<br><i>Balto. Co. Md.</i>                                                            |  |
| 24 FUNERAL DIRECTOR NAME<br><i>Joseph L. Russ</i>                                                                                                                                                                                                                                                                 |  | ADDRESS<br><i>2222 W. North Ave</i>                                                                                                                                                                                                                                                                                                                                              |  | 25 DATE REC'D. BY REGISTRAR<br><i>APR 23 1986</i>                                                                                                       |  | 25a REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                                                                       |  |

BP

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C. 20315

100-104874





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10677

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                     |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ERNEST FLOWERS III</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-18-86</b>                  |                                                                                                                                                             |                                                                                                 | 2b. HOUR<br><b>4:30 M</b>                                                                                                  |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>BLACK</b>                                                                                                                             |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 6 85</b>                                                                                                         |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>1</b>                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                                        |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b> |                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>—</b>                                                                                |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                                                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br><b>MARYLAND BALTIMORE</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                     | 13b. CITY OR TOWN<br><b>BALTIMORE</b>                                  |                                                                                                                                                             | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ERNEST FLOWERS</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BREITA GILLARD</b> |                                                                                                                                                             |                                                                                                 |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>—</b>                                   |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>ADMISSION SHEET</b>                                              |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRAIN DEATH</b><br><b>912</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARDIOPULMONARY ARREST</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>ASPIRATION</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>~40 HRS.</b> |  |                                                                                                                                                     |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                     |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>                                                                                        |                                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                   |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                              |                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                 |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/16</b> , 19 <b>86</b> , to <b>4/18</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/18</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                    |  |                                                                                                                                                     |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Lisa A. Horton MD</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                     |                                                                        | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                                 | 22c. DATE SIGNED<br><b>4-18-86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LISA A. HORTON</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                     |                                                                        | 22e. ADDRESS<br><b>222 S. GREECE ST Rm N5EQ5</b>                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>04-23-86</b>                                                                                                                        |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN CEM</b>                                                                                                 |                                                                                                 | 23d. LOCATION<br>(CITY OR TOWN) (COUNTY) (STATE)<br><b>BALTIMORE, MARYLAND</b>                                             |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>BROWN THOMPSON F.H. 1913 W. BALTO. ST.</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                     |                                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 22 1986</b>                                                                                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>                                                                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 27 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified about it.

(A)

NEWLAND

NEWLAND

BACK

CITY

UNIVERSITY OF MICHIGAN LIBRARY

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 6 7 8

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George Walter Flowers</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 26, 1986</b>                                    |                                                                                | 2b. HOUR<br><b>11:00a.m.</b>                                                                                               |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br><b>White</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 28, 1902</b>                                                                                                  |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4217 Nicholas Avenue 21206</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>            |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                | 13b. COUNTY                                                                                                                                    | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>4217 Nicholas Avenue 21206</b>            |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth unknown</b>                                                                                        |                                                                                                 |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>256-07-1902</b>                                                                  | 17. INFORMANT ADDRESS<br><b>Eutha H. Flowers same as 13e</b>                                                                                                |                                                                                                 |                                                                                |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ischemic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Senile COPD</b>                                                                                                                                                                                                                          |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                            |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                     |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br><b>Gracito V. Patricio, M.D.</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                | DEGREE                                                                                                                                                      |                                                                                                 | 22c. DATE SIGNED<br><b>4/26/86</b>                                             |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gracito V. Patricio, M.D.</b>                                                                                                                                                                                                                                                                                                    |                                                                                                                                                | 22e. ADDRESS<br><b>2926 E. Cold Spring Road</b>                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                   | 23b. DATE<br><b>4/29/1986</b>                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Memorial Pk.</b>                                                                                          |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Falls Church Fairfax, VA</b>  |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                             |                                                                                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1986</b>                                                                                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>                               |                                                                                                                            |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

20 X 20 1/2 X 10 1/2



0-05390

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report obtained.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 0 6 7 9  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                             |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Anna C. Foessel</i>                                                                                                                                                                                                                                                            |                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>4/29/86</i>                                                                                                          |                                                                                      | 2b. HOUR<br><i>4:50 PM</i>                                                                      |                                                                                                                            |
| 3. SEX<br><i>FEMALE</i>                                                                                                                                                                                                                                                                                                                       | 4. RACE<br><i>White</i>                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11/19/1898</i>                                                                                                     |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>88</i> YRS.                                               |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Germany</i>                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City, MD.</i>                              |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Good Samaritan Hospital</i> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><i>Maryland</i>                                                                                                                                                                                                                               |                                                                                                                                             | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>/ Heinrich Schradners</i>                                                                                                                                                                                                                                                                        |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>UNKNOWN</i>                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>                                                                                                                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>213-10-5047</i>                                                               | 17. INFORMANT ADDRESS<br><i>Mrs. Janice V. Foessel 1238 Lake Falls Rd. 21210</i>                                                                            |                                                                                      |                                                                                                 |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c) |                                                                                                                                             |                                                                                                                                                             |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                        |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                       |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                  |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)                                                                                       |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/25/86</i> to <i>4/29/86</i> , that (I) (we) last saw the deceased alive on <i>4/29/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |                                                                                                                                             |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><i>W. J. J.</i>                                                                                                                                                                                                                                                                                                             |                                                                                                                                             | DEGREE                                                                                                                                                      |                                                                                      | 22c. DATE SIGNED                                                                                |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>WALID JARWI, MD</i>                                                                                                                                                                                                                                                                               |                                                                                                                                             | 22e. ADDRESS<br><i>Good Samaritan Hospital</i>                                                                                                              |                                                                                      |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                 | 23b. DATE<br><i>5-2-86</i>                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Dulaney Valley</i>                                                                                                 |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Timonium Maryland</i>                          |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Leonard J. Ruck, Inc.</i>                                                                                                                                                                                                                                                                                  |                                                                                                                                             | ADDRESS<br><i>Baltimore, Md.</i>                                                                                                                            |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 2 1986</i>                                              |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |                                                                                      |                                                                                                 |                                                                                                                            |

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0-04919

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed in the Bureau after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, only injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 6 8 0

|                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                 |                                                                                                        | REG. NO.                                                                                                                                                 |                                                                                                                         |
| I. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                       |                                                                                                        | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                         |                                                                                                                         |
| ROBERT P. FOLK                                                                                                                                                                                                                                         |                                                                                                        | 04/25/86 2 48 P                                                                                                                                          |                                                                                                                         |
| 1. SEX                                                                                                                                                                                                                                                 | 4. RACE                                                                                                | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.                                                                                    |
| Male                                                                                                                                                                                                                                                   | White                                                                                                  | July 22, 1923                                                                                                                                            | 62                                                                                                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |
| Maryland                                                                                                                                                                                                                                               | U.S.A.                                                                                                 |                                                                                                                                                          | BALTIMORE CITY MD.                                                                                                      |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |
| BALTIMORE                                                                                                                                                                                                                                              | UNION MEMORIAL HOSPITAL                                                                                | Self-Employed-                                                                                                                                           | Sewer Co.                                                                                                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                           | 13b. CITY OR TOWN                                                                                      | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             | 13e. STREET ADDRESS / ZIP CODE                                                                                          |
| Maryland Baltimore                                                                                                                                                                                                                                     | Parkville                                                                                              |                                                                                                                                                          | 1036 Deanwood Rd. 21234                                                                                                 |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                    | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES                                                               |                                                                                                                         |
| Iyman                                                                                                                                                                                                                                                  | Rosina Kraus                                                                                           | Yes WW II                                                                                                                                                |                                                                                                                         |
| 17a. SOCIAL SECURITY NO                                                                                                                                                                                                                                | 17. INFORMANT ADDRESS                                                                                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest                 |                                                                                                                         |
| 098-12-6686                                                                                                                                                                                                                                            | Mrs. Bertha E. Folk Same as # 13e                                                                      | (b) Pseudomonas Aeruginosa Septic                                                                                                                        |                                                                                                                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Lymphocytic Leukemia Prostatitis                                                                              |                                                                                                        |                                                                                                                                                          |                                                                                                                         |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 4/21/86 TURP                                                                                                                                                                                                                                           | BENIGN PROSTATIC HYPERPLASIA                                                                           |                                                                                                                                                          |                                                                                                                         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                     | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |                                                                                                                         |
|                                                                                                                                                                                                                                                        | P.M. 19                                                                                                |                                                                                                                                                          |                                                                                                                         |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                         |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                                                                                         |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/7, 19 86, to 4/25, 19 86, and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                                                                         |
| 22b. SIGNATURE                                                                                                                                                                                                                                         | DEGREE                                                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               | 22c. DATE SIGNED                                                                                                        |
| Mertine R. Jermany MD                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          | 4/25/86                                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                  | 22e. ADDRESS                                                                                           |                                                                                                                                                          |                                                                                                                         |
| MERTINE R. JERMANY                                                                                                                                                                                                                                     | UNION MEMORIAL HOSPITAL                                                                                |                                                                                                                                                          |                                                                                                                         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                              | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |
| Burial                                                                                                                                                                                                                                                 | 4-29-86                                                                                                | Moreland Mem. Park                                                                                                                                       | Baltimore, Maryland                                                                                                     |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                      |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE                                                                                                 |                                                                                                                         |
| Leonard J. Ruck, Inc. Baltimore, Md.                                                                                                                                                                                                                   |                                                                                                        | APR 28 1986 Julia Davidson-Randall                                                                                                                       |                                                                                                                         |



General J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.



00-02689

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                     |        |                                                                                                            |                                                             |                                                                                                                                                          |                                                                               |                                                                     |                                            |                                                                     |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |                                                                                                            |                                                             |                                                                                                                                                          |                                                                               |                                                                     |                                            |                                                                     |                                              |
| REG. NO. 10681                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |                                                                                                            |                                                             |                                                                                                                                                          |                                                                               |                                                                     |                                            |                                                                     |                                              |
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                          |        |                                                                                                            | FIRST MIDDLE LAST                                           |                                                                                                                                                          |                                                                               | 2a DATE KNOWN OF DEATH                                              |                                            | 2b HOUR                                                             |                                              |
| Blanche M. Ford                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |                                                                                                            |                                                             |                                                                                                                                                          |                                                                               | X MONTH DAY YEAR<br>4/ 1/ 19 86                                     |                                            | M                                                                   |                                              |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4 RACE | 5 DATE OF BIRTH                                                                                            | 6 AGE (IN YEARS)                                            | IF UNDER 1 YR.                                                                                                                                           | IF UNDER 24 HRS.                                                              | 2c DATE PRONOUNCED DEAD                                             |                                            | 2d HOUR                                                             |                                              |
| F                                                                                                                                                                                                                                                                                                                                                                                                                                                           | B      | 9 11 09                                                                                                    | 76 YRS.                                                     | MONTHS DAYS HOURS MIN.                                                                                                                                   |                                                                               | 4/ 1/ 19 86                                                         |                                            | 11:22 A M                                                           |                                              |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                    |        | 7b CITIZEN OF WHAT COUNTRY?                                                                                |                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                                            |                                                                     |                                              |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                    |        | U.S.A.                                                                                                     |                                                             |                                                                                                                                                          |                                                                               | Baltimore City, MD                                                  |                                            |                                                                     |                                              |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                    |        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                             |                                                                                                                                                          |                                                                               | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |                                            | 12b KIND OF BUSINESS OR INDUSTRY                                    |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        | 422 E. 25th Street                                                                                         |                                                             |                                                                                                                                                          |                                                                               | DOMESTIC                                                            |                                            |                                                                     |                                              |
| 13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                              |        |                                                                                                            |                                                             |                                                                                                                                                          |                                                                               |                                                                     |                                            |                                                                     |                                              |
| 13a STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        | 13b COUNTY                                                                                                 |                                                             | 13c CITY OR TOWN                                                                                                                                         |                                                                               | 13d INSIDE CITY LIMITS?                                             |                                            | 13e STREET ADDRESS                                                  |                                              |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                    |        |                                                                                                            |                                                             | BALTIMORE                                                                                                                                                |                                                                               | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                            | 422 E. 25th ST. 21218                                               |                                              |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                            |        |                                                                                                            |                                                             |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME                                                      |                                                                     |                                            |                                                                     |                                              |
| JAMES F. WATKINS SR.                                                                                                                                                                                                                                                                                                                                                                                                                                        |        |                                                                                                            |                                                             |                                                                                                                                                          | BLANCHE E. FREDRICKS                                                          |                                                                     |                                            |                                                                     |                                              |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                        |        |                                                                                                            | 16b SOCIAL SECURITY NO.                                     |                                                                                                                                                          | 17 INFORMANT ADDRESS                                                          |                                                                     |                                            |                                                                     |                                              |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |                                                                                                            | 214-20-4602D                                                |                                                                                                                                                          | MILDRED A. FORD 422 E. 25th. ST.                                              |                                                                     |                                            |                                                                     |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                |        |                                                                                                            |                                                             |                                                                                                                                                          |                                                                               |                                                                     |                                            |                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                                              |        |                                                                                                            |                                                             |                                                                                                                                                          |                                                                               |                                                                     |                                            |                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                                                                                                                                          |                                                                               |                                                                     |                                            | 20 AUTOPSY?                                                         |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |                                                                                                            |                                                             |                                                                                                                                                          |                                                                               |                                                                     |                                            | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                         |        |                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                     |                                            |                                                                     |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    |        |                                                                                                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                                                                                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                     |                                            |                                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |        |                                                                                                            |                                                             |                                                                                                                                                          |                                                                               |                                                                     |                                            |                                                                     |                                              |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                            |        |                                                                                                            | TITLE (SPECIFY)                                             |                                                                                                                                                          |                                                                               |                                                                     |                                            | DATE SIGNED                                                         |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |                                                                                                            | M.D. Assistant MEDICAL EXAMINER                             |                                                                                                                                                          |                                                                               |                                                                     |                                            | 4/1/86                                                              |                                              |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                          |        |                                                                                                            | ADDRESS                                                     |                                                                                                                                                          |                                                                               |                                                                     |                                            |                                                                     |                                              |
| Gregory R. Kauffman, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |                                                                                                            | 111 Penn St.                                                |                                                                                                                                                          |                                                                               |                                                                     |                                            |                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                   |        |                                                                                                            | 23b. DATE                                                   |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY                                            |                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                                                     |                                              |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |                                                                                                            | 4-7-86                                                      |                                                                                                                                                          | CHURCH CEMETERY                                                               |                                                                     | CHESTER MARYLAND                           |                                                                     |                                              |
| 24 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                         |        |                                                                                                            | 25a. DATE REC'D. BY REGISTRAR                               |                                                                                                                                                          |                                                                               |                                                                     |                                            | 25b. REGISTRAR'S SIGNATURE                                          |                                              |
| WM.C.MARCH F/H INC. 1101 E. NORTH AVE.                                                                                                                                                                                                                                                                                                                                                                                                                      |        |                                                                                                            | APR 07 1986                                                 |                                                                                                                                                          |                                                                               |                                                                     |                                            |                                                                     |                                              |

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000-04369

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

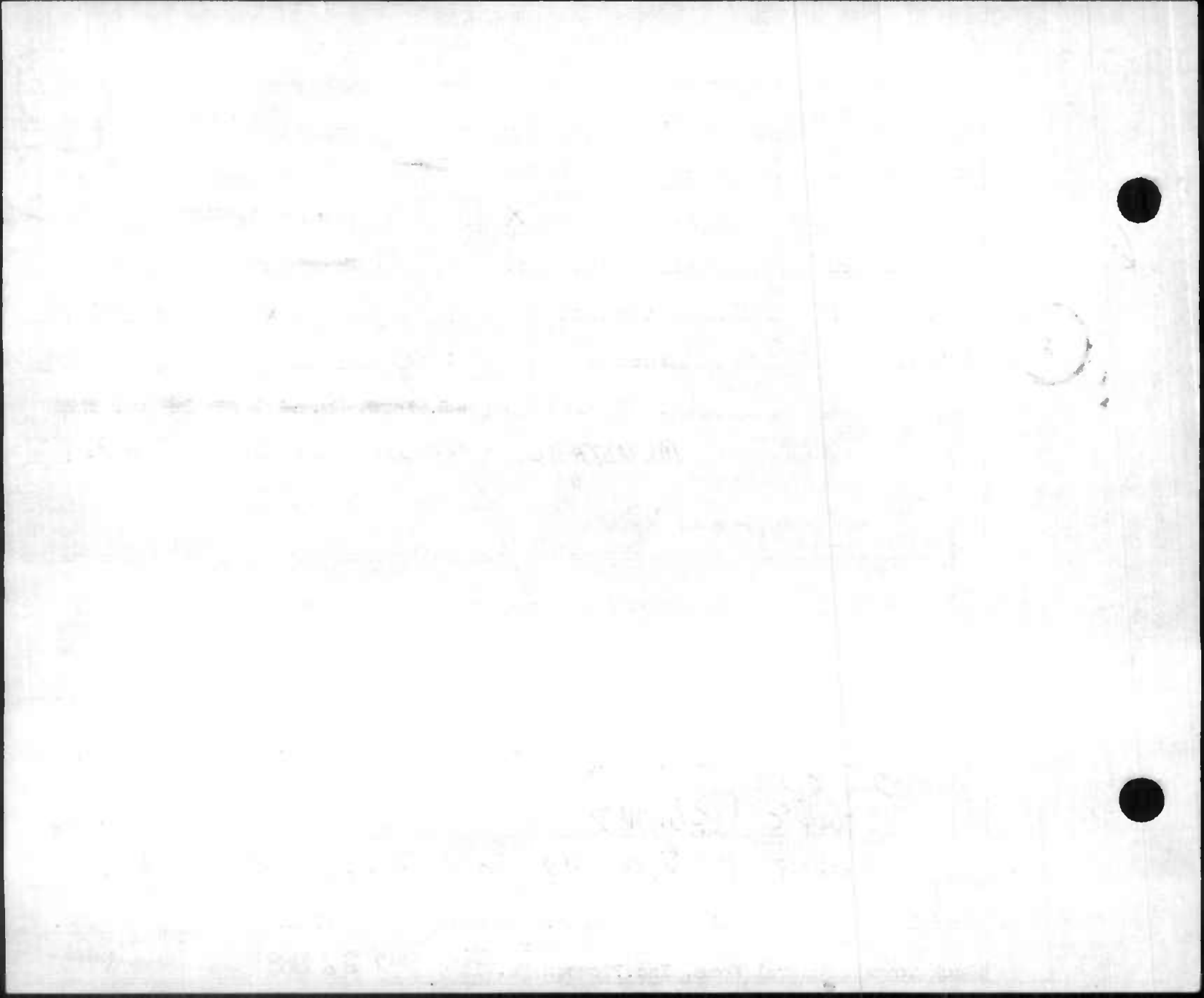
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                               |                                                  |                                                                                                                                                             |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Minna M. Ford                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4-18-1986 |                                                                                                                                                             |  | 2b. HOUR<br>6:15A                                                                                                          |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>White                                                                                                              |                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 21, 1899                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                          |                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, City MD.                                                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Wesley Home Inc. |                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                              |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY                                                                                                                   |                                                  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Adolph Tuerke                                                                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Appel                                                                 |                                                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                      |  |                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO.<br>212-42-3316                                                                                                                                                                                                                                                                                                                                                                                 |  | 17. INFORMANT<br>ADDRESS<br>John R. Ford, Jr. -101 Sipple Ave. 21236                                                          |                                                  |                                                                                                                                                             |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC CARCINOMA of BREAST<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YEARS |  |                                                                                                                               |                                                  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.                                                                                                                                                                                                                                                                                     |  |                                                                                                                               |                                                  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                              |                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (this hospital) attended the deceased from 4-14 1986, 7-1 1986, to 4/18 1986, that (we) last saw the deceased alive above (if (we) (did) (did not) view the body after death.                                                                                                                                                                                                                       |  |                                                                                                                               |                                                  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Robert E. Roby MD                                                                                                                                                                                                                                                                                                                                                                                     |  | DEGREE                                                                                                                        |                                                  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>4-18-86                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT E. ROBY, M.D.                                                                                                                                                                                                                                                                                                                                                           |  | 22e. ADDRESS<br>8817 Belair Rd.                                                                                               |                                                  | 21236                                                                                                                                                       |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>4-21-86                                                                                                          |                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. National                                                                                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS<br>1050 York Rd.<br>Towson, Md. 21204                                                                                 |                                                  | 25a. DATE REC'D. BY REGISTRAR<br>APR 22 1986                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                                                       |  |

BP

DHMH-16 50M 1/81  
(VRA 15, 4)



00-03210

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                     |  |                                                                                                                                                            |  | 86 10683                                                                                     |  |                                                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                            |  | REG. NO.                                                                                     |  |                                                                                                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Frances Mae Foster</b>                                                                                                                                                                                                                                                       |  |                                                                                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><b>4 7 86</b>                                   |  |                                                                                                                                       |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                   |  | 4 RACE<br><b>White</b>                                                                                                                                     |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>5/27/06</b>                                             |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>79</b> YRS.                                                                                    |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                            |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD                             |  |                                                                                                                                       |  |
| 11 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b>                        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Textile Mill</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                            |  | 13b. CITY OR TOWN<br><b>Oella</b>                                                                                                                          |  | 13c. STREET ADDRESS / ZIP CODE<br><b>714 Oella Ave. Ellicott City, Md.</b>                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Dwyer</b>                                                                                            |  |                                                                                              |  |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>213096087</b>                                                                                                               |  | 17. INFORMANT ADDRESS<br><b>M's Alice Taylor 935 Oella Ave., Ellicott City 21043</b>         |  |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>ACUTE MYOCARDIAL INFARCTION</b>                                                                                                                                                                             |  |                                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                 |  |                                                                                                                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). <b>Coronary Atherosclerosis</b>                                                                                                                                                                                                      |  |                                                                                                                                                            |  |                                                                                              |  |                                                                                                                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (c).                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                            |  |                                                                                              |  |                                                                                                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a. <b>CONGESTIVE HEART FAILURE; DIABETES MELLITUS</b>                                                                                                                                                   |  |                                                                                                                                                            |  |                                                                                              |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>N/A</b>                                                                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.<br><b>N/A 19</b>                                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b> |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/><br><b>N/A</b>                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b>                                                                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>                                 |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 1 1980</b> to <b>APRIL 7 1986</b> that (I) (we) last saw the deceased alive on <b>April 7 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                            |  |                                                                                              |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Randy L. Reese, M.D.</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                            |  | DEGREE<br><b>M.D.</b>                                                                        |  | 22c. DATE SIGNED<br><b>4/7/86</b>                                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RANDY L. REESE, M.D.</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                                            |  | 22e. ADDRESS<br><b>2850 NORTH RING RD ELLEICOTT CITY, MD 21043</b>                           |  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>April 10'86</b>                                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Old Salem Luth. Church</b>                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Catonsville Balto., Maryland</b>                                                        |  |
| 24. FUNERAL DIRECTOR<br><b>Harry H Witzke &amp; Family Funeral Home Inc 4112 Old Columbia Pike Ellicott City</b>                                                                                                                                                                                                                         |  |                                                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 10 1986</b>                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>                                                                                      |  |

01510-01



2008 OCTOBER 12  
12:12 PM

00-02958

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10684  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GLORIA Diane FORSTER                                                                                                                                                                                                                                                                                               |                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 7 1986                                             |                                                                                      | 2b. HOUR<br>10:00 PM                                                                                                       |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                               | 4. RACE<br>White                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 5 42                                                                                                                |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Maryland                                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed                  |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                         | 13b. COUNTY<br>Baltimore                                                                                                     | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Leonard Forster                                                                                                                                                                                                                                                                                                               |                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Margaret Roth                                                                                        |                                                                                                 |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, YES, UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-40-0359                                                       | 17. INFORMANT<br>ADDRESS<br>Marie M. Adamczyk 7252 Conley St. 21224                                                                                         |                                                                                                 |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>sever liver cirrhosis with coagulopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____                                                                                                                                                                                                                                     |                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                       |                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I. OR PART 2)      |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                 |                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (a) (the hospital) attended the deceased from <u>MARCH 24</u> 19 <u>86</u> , to <u>APRIL 7</u> 19 <u>86</u> , that (b) (we) last saw the deceased alive on <u>APRIL 7</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (I) did not view the body after death.              |                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br>Theresa Adams MD                                                                                                                                                                                                                                                                                                                                             |                                                                                                                              | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                                 | 22c. DATE SIGNED                                                                     |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Theresa Adams                                                                                                                                                                                                                                                                                                                         |                                                                                                                              | 22e. ADDRESS<br>CHURCH HOSPITAL <del>XXXXX</del><br>100 N. BROADWAY, BALTIMORE, MD. 21231                                                                   |                                                                                                 |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                         | 23b. DATE<br>4-11-86                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery                                                                                                     |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Eastwood, Balto. Co., Md.              |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles S. Zeiler & Son Inc.                                                                                                                                                                                                                                                                                                                   |                                                                                                                              | ADDRESS<br>6224 Eastern Ave.                                                                                                                                |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>APR 09 1986                                         |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                              | 25b. REGISTRAR'S SIGNATURE<br>Janae Warden                                                                                                                  |                                                                                                 |                                                                                      |                                                                                                                            |





00-03599

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-6

10685

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                                                                                            |                                                                                                                                            |                                                                  |                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------|
| DECEASED NAME<br>(TYPE OR PRINT) <b>REGINA G. FORSYTHE</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                            |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH <b>4</b> DAY <b>12</b> YEAR <b>86</b>                                                                            |                                                                  | 2b HOUR<br><b>10<sup>53</sup> P M</b>               |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                      | 4 RACE<br><b>White</b>                                                                                                                     | 5 DATE OF BIRTH<br>MONTH <b>Oct.</b> DAY <b>16</b> YEAR <b>1911</b>                                                                                        |                                                                                                                                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                 | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>      |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                       | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |                                                     |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                        |                                                                  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>MD</b>                                                                                                                                                                                                                                                                                          | 13b COUNTY <b></b>                                                                                                                         | 13c CITY OR TOWN<br><b>Balto.</b>                                                                                                                          | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                             | 13e STREET ADDRESS / ZIP CODE<br><b>700 W. 40th St., 21211</b>   |                                                     |
| 14 FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>A.</b> LAST <b>Forsythe</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Katherine</b> MIDDLE <b>R.</b> LAST <b>Lowry</b>                                                                       |                                                                                                                                            |                                                                  |                                                     |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                            | 16b SOCIAL SECURITY NO.<br><b>216 12 6913</b>                                                                                              | 17 INFORMANT ADDRESS<br><b>Mrs. Edna Dresbach, Towson, MD</b>                                                                                              |                                                                                                                                            |                                                                  |                                                     |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>MASSIVE ACUTE Myocardial Infarction, Sudden death</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> |                                                                                                                                            |                                                                                                                                                            |                                                                                                                                            |                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                          |                                                                                                                                            |                                                                                                                                                            |                                                                                                                                            |                                                                  |                                                     |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                       | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |                                                                  |                                                     |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                     | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19 86</b>                                                                        | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                                                                            |                                                                  |                                                     |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                                            |                                                                  |                                                     |
| 22a I certify that (I) (this hospital) attended the deceased from <b>4/8/86</b> to <b>4/12/86</b> , that (I) (we) last saw the deceased alive on <b>4/12/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.                                                                                   |                                                                                                                                            |                                                                                                                                                            |                                                                                                                                            |                                                                  |                                                     |
| 22b SIGNATURE<br><b>Paul C. Marinelli</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                            | DEGREE<br><b>MD</b>                                                                                                                                        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED<br><b>4/12/86</b>                                |                                                     |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL C. MARINELLI M.D.</b>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                            | 22e ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                              |                                                                                                                                            |                                                                  |                                                     |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                   | 23b DATE<br><b>4/16/86</b>                                                                                                                 | 23c NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                                                                                                  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b>                                                                             |                                                                  |                                                     |
| 24 FUNERAL DIRECTOR<br>NAME <b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS <b>4905 York Road Balto., MD 21212</b>                                                                                                                                                                                                                                                                                        |                                                                                                                                            |                                                                                                                                                            | 25a DATE REC'D. BY REGISTRAR                                                                                                               | 25b REGISTRAR'S SIGNATURE<br><b>APR 15 1986</b>                  |                                                     |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

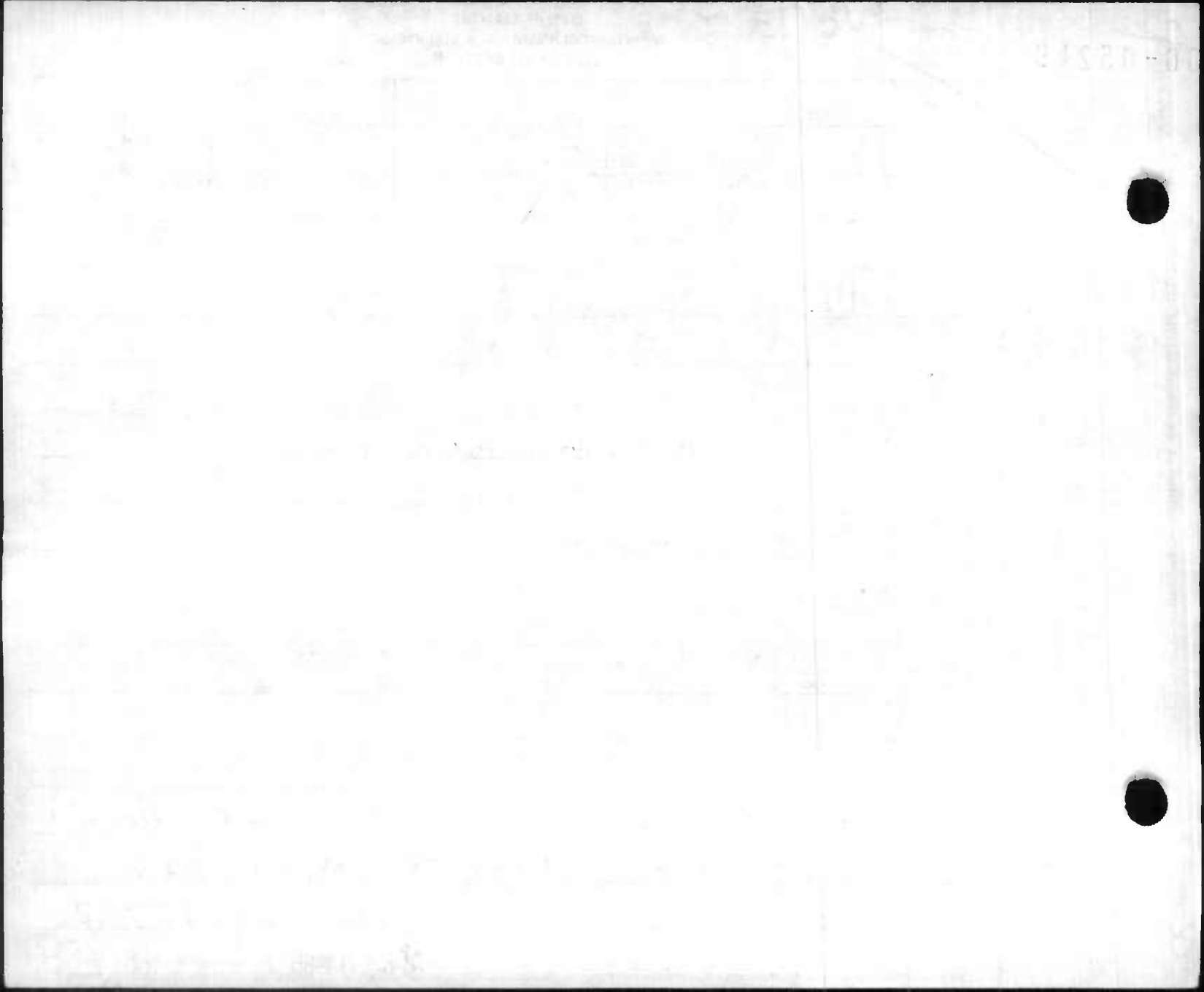
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DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH


8610686  
REG. NO.1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                             |                                                                                                                                                             |                                                                    |                                                                                |                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Maryland Fortune                                                                                                                                                                                                                                                                                                      |                                                                                                                             |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>04-23-86                    |                                                                                | 2b. HOUR<br>M                                                                                   |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                             | 4. RACE<br>Black                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08-14-1919                                                                                                            |                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |                                                                                                 |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                       |                                                                                                                             |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                                           | 13c. CITY OR TOWN<br>Baltimore                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sam Scales                                                                                                                                                                                                                                                                                                         |                                                                                                                             |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl Lane Scales |                                                                                |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                   |                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>095-22-4592                                                                                      |                                                                    | 17. INFORMANT<br>ADDRESS<br>Hayward Fortune 8045 Greenleaf Terr.               |                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <u>Acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b). <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c). <u>Hypertension</u>                                                         |                                                                                                                             |                                                                                                                                                             |                                                                    |                                                                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>Multiple CVA's Decubitus ulcer</u>                                                                                                                                                                                 |                                                                                                                             |                                                                                                                                                             |                                                                    |                                                                                |                                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                     |                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                 |                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-23</u> 19 <u>86</u> , to <u>4-23</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4-23</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                             |                                                                                                                                                             |                                                                    |                                                                                |                                                                                                 |
| 22b. SIGNATURE<br><u>Marshall J. Brown</u>                                                                                                                                                                                                                                                                                                                   |                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                    | 22c. DATE SIGNED<br>4/28/86                                                    |                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marshall J. Brown                                                                                                                                                                                                                                                                                                   |                                                                                                                             | 22e. ADDRESS<br>844 N. Carey St. 21217                                                                                                                      |                                                                    |                                                                                |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                       | 23b. DATE<br>04-30-86                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National                                                                                                    |                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland              |                                                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brown/Thompson F.H.                                                                                                                                                                                                                                                                                                          |                                                                                                                             | ADDRESS<br>1913 W. Baltimore Street                                                                                                                         |                                                                    | 25a. DATE REC'D. BY REGISTRAR<br>APR 30 1986                                   | 25b. REGISTRAR'S SIGNATURE<br><u>Wm Davidson Rindell</u>                                        |



00-05090

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10687  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                               |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lauretta France</b>                                                                                                                                                                                                                                                                                                                                |                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 25 86</b>                                           |                                                                               | 2b. HOUR<br><b>9:20 p.m.</b>                                                                                               |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>White</b>                                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 4, 1901</b>                                                                                                  |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS                              |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>             |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>                                                                       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS ZIP CODE<br><b>3812 6th Street 21225</b>                  |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Theodore Drager</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary C. Schwaab</b>                                                                                     |                                                                                                 |                                                                               |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>                                                                 | 17. INFORMANT<br>ADDRESS<br><b>Mary Lee Horst 5601 Chatham road 21225</b>                                                                                   |                                                                                                 |                                                                               |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Massive inferior + right ventricular infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)                                                                                                                                                                                                                                                         |                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                               |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                      |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                 |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)                                                                                          |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/25 1986</b> to <b>4/25 1986</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/25 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                     |                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                               |                                                                                                                            |
| 22b. SIGNATURE<br>                                                                                                                                                                                                                                                                                        |                                                                                                                                        | DEGREE                                                                                                                                                      |                                                                                                 | 22c. DATE SIGNED<br><b>4/25/86</b>                                            |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jose Fernandez, M.D.</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                        | 22e. ADDRESS<br><b>St Agnes Hospital Caton Ave. Balt., Md 21229</b>                                                                                         |                                                                                                 |                                                                               |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                | 23b. DATE<br><b>4-29-1986</b>                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk.</b>                                                                                            |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>     |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home</b>                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                        | 237 E. Patapsco Ave<br>Balt. Md. 21225                                                                                                                      |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 29 1986</b>                           |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                        | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |                                                                                                 |                                                                               |                                                                                                                            |

00-02004

NOTION 2002

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00-04783

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10688

REG. NO.

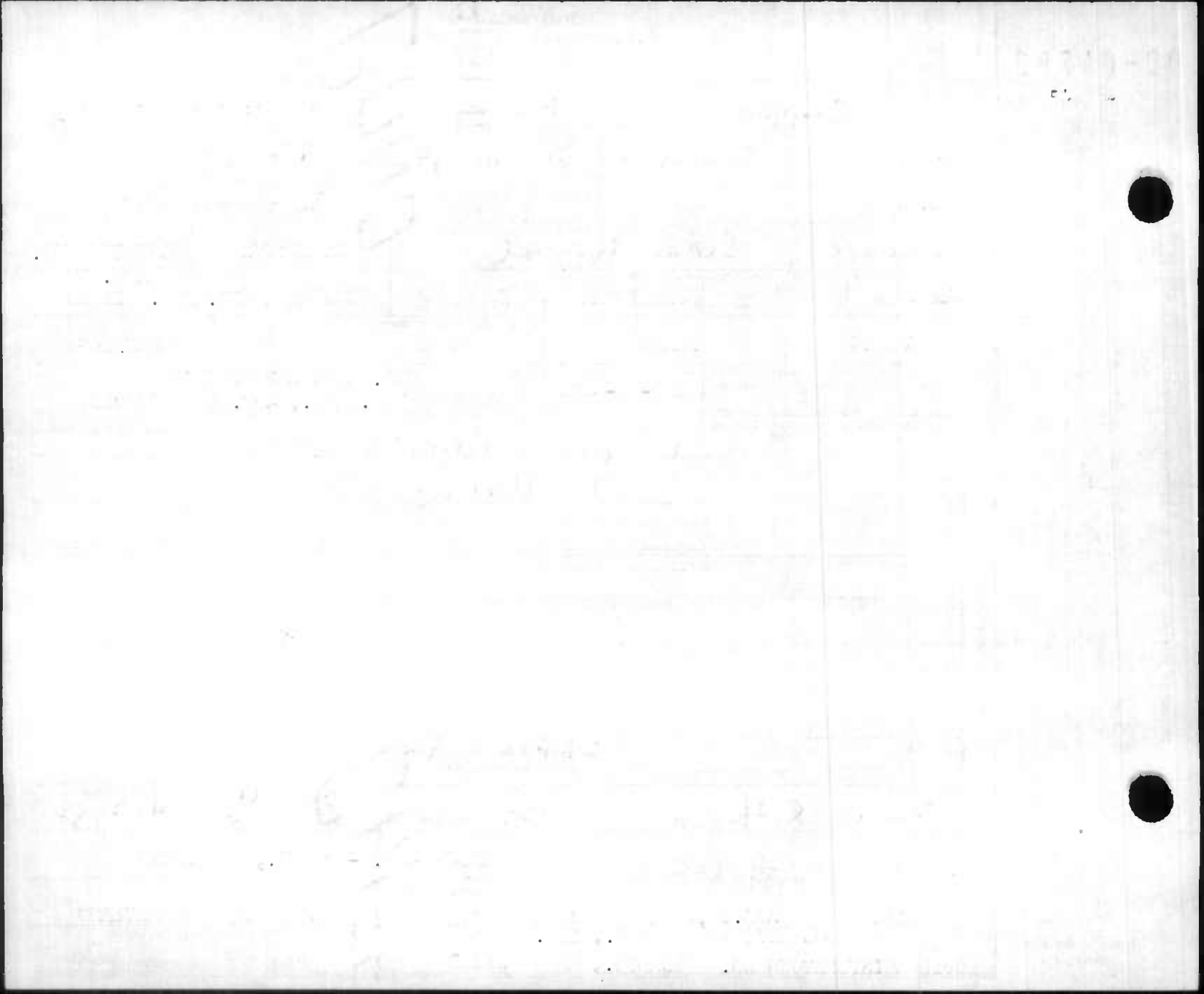
1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                  |  |                                                                                                                             |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Cupple Frank                                                                                                                                                                                                                                              |  |                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4-21-86 |                                                                                                                                                             |  | 2b. HOUR<br>130 AM                                                                              |  |                                                                                                                               |  |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>Caucasian                                                                                                        |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 06 94                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.                                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>MARYLAND                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         |                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>EXECUTIVE                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CLOTHING MFG.                                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                          |  |                                                                                                                             |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
| 13a. MARYLAND                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY                                                                                                                 |                                                | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>6503 PARK HTS. AVE. 21215                                                                   |  |
| 14. FATHER'S NAME<br>MORRIS                                                                                                                                                                                                                                                                      |  |                                                                                                                             |                                                | 15. MOTHER'S MAIDEN NAME<br>ROSA ROSENBERG                                                                                                                  |  |                                                                                                 |  |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>214-01-6921                                                                                     |                                                | 17. INFORMANT<br>ADDRESS<br>MRS. MINDELLE STRAUSS<br>6503 PARK HTS. AVE., APT. 1H #21215                                                                    |  |                                                                                                 |  |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) G.I. bleeding<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                   |  |                                                                                                                             |                                                |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                               |  |                                                                                                                             |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                            |                                                |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                  |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                      |                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 21 Apr 1986, to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                             |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
| 22b. SIGNATURE<br>Daniel C. Hagan                                                                                                                                                                                                                                                                |  |                                                                                                                             |                                                | DEGREE<br>DO. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |  |                                                                                                 |  | 22c. DATE SIGNED<br>4-21-86                                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Daniel C Hagan                                                                                                                                                                                                                                          |  |                                                                                                                             |                                                | 22e. ADDRESS<br>SINAI HOSP. - BALTO., MD 21215                                                                                                              |  |                                                                                                 |  |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                           |  | 23b. DATE<br>APR. 22, 1986                                                                                                  |                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMUNO                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                |  |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                                                                                                             |  |                                                                                                                             |                                                | 25a. DATE REC'D. BY REGISTRAR<br>APR 25 1986                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson                                                     |  |                                                                                                                               |  |

MEDICAL CERTIFICATION

BP

DHMM - 16 50M 4/83  
(VRA 15, 4)





00-046261

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10689

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                             |                                                                                                                                                             |                                                                            |                                                                                |                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Randolph C. Franklin                                                                                                                                                                                                                                                                                                                                            |                                                                                                                             |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 15, 1986                      |                                                                                | 2b. HOUR<br>8 <sup>00</sup> /P.M.                                                                                             |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br>BLACK                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 23 17                                                                                                              |                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CHARLOTTE VA                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                    |                                                                                |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br>BALTO.                                                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHN L. DEATON |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>WELDER |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                             |                                                                                                                                                             | 13b. COUNTY                                                                | 13c. CITY OR TOWN<br>BALTO                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                             |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN Lizzie Franklin   |                                                                                |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>UNKNOWN                                                                                                                                                                                                                                                                                            |                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>229-183409                                                                                                                      |                                                                            | 17. INFORMANT<br>ADDRESS PHILA PA 19131<br>AUDREY BAKER - 5731 WYNDALE AVE     |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiration pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>multiple CVA's</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>severe peripheral vascular disease.</u>                                                                                       |                                                                                                                             |                                                                                                                                                             |                                                                            |                                                                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>new onset diabetes mellitus.</u>                                                                                                                                                                                                                                |                                                                                                                             |                                                                                                                                                             |                                                                            |                                                                                |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               |                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                           |                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                               |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>7 October</u> 19 <u>85</u> to <u>15 April</u> 19 <u>86</u> , that (I) <u>(we)</u> lost<br>saw the deceased <u>on</u> <u>15 April</u> 19 <u>86</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <u>(we)</u> (did) (did not) view the body after death. |                                                                                                                             |                                                                                                                                                             |                                                                            |                                                                                |                                                                                                                               |
| 22b. SIGNATURE<br><u>John A. Goepel.</u>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                             | DEGREE<br><u>MD</u>                                                                                                                                         |                                                                            | 22c. DATE SIGNED<br><u>16 Apr 86</u>                                           |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                             | 22e. ADDRESS                                                                                                                                                |                                                                            |                                                                                |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK BY)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                             | 23b. DATE<br><u>4-18-86</u>                                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cem.</u>               |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTO. CO. MD.</u>                                                           |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Joseph L. Russ</u>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                             | ADDRESS<br><u>2222 W. North Ave.</u>                                                                                                                        |                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><u>APR 23 1986</u>                            |                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                             | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |                                                                            |                                                                                |                                                                                                                               |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1922. 2. 10

USA



0-05465

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO.

10690

|                                                                                              |  |                                                                                                                                                     |                                                       |                                                                                                                                                             |  |                                                                                                 |  |
|----------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Derrick Lamont Frazier Jr</b> |  |                                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 30 86</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>105 AM</b>                                                                       |  |
| 3. SEX<br><b>Male</b>                                                                        |  | 4. RACE<br><b>Black</b>                                                                                                                             |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 29 86</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>0 0 10 39</b>                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                          |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b> |                                                       |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><b>Maryland</b>                                                                |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                     |                                                       | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Derrick Lamont Frazier</b>                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carla Jeannette Rose</b>                                                                        |                                                       | 16. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                                       |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>            |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                              |                                                       | 17. INFORMANT<br>ADDRESS<br><b>HANCY Caldwell 1026 Appleton Street 21217</b>                                                                                |  |                                                                                                 |  |

|                                                                                                                                                                |  |                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last                       |  | (b) <b>hypoplastic lungs</b>                    |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                 |  | (c)                                             |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                      |  |                                                                                              |  |                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br><b>4/29/86</b>                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Diaphragmatic Hernia</b>      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b> |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>                              |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-29 @ 2:25 PM 1986</b> to <b>4-30 @ 05:15 1986</b> , that (I) (we) lost<br>saw the deceased alive on <b>4-29 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If I was a third party, I did not view the body after death.) |  |                                                                                      |  |                                                                                              |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Charles Cheng</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                      |  | DEGREE<br><b>M.D.</b>                                                                        |  | 22c. DATE SIGNED<br><b>4/30/86</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES CHENG M.D.</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                      |  | 22e. ADDRESS<br><b>Univ. of Maryland Hospital, BALTO, MD</b>                                 |  |                                                                                                                               |  |

|                                                                               |  |                            |  |                                                         |  |                                                                       |  |
|-------------------------------------------------------------------------------|--|----------------------------|--|---------------------------------------------------------|--|-----------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                              |  | 23b. DATE<br><b>5-5-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNE ARUNDEL MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WM.C.MARCH F/H INC. 1101 E. NORTH AVE.</b> |  |                            |  | 25a. DATE RECEIVED BY REGISTRY<br><b>MAY 2 1986</b>     |  | 25b. REGISTERED<br><b>John H. H. H.</b>                               |  |

U.S. COAST GUARD

U.S. COAST GUARD



112

00-04211

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

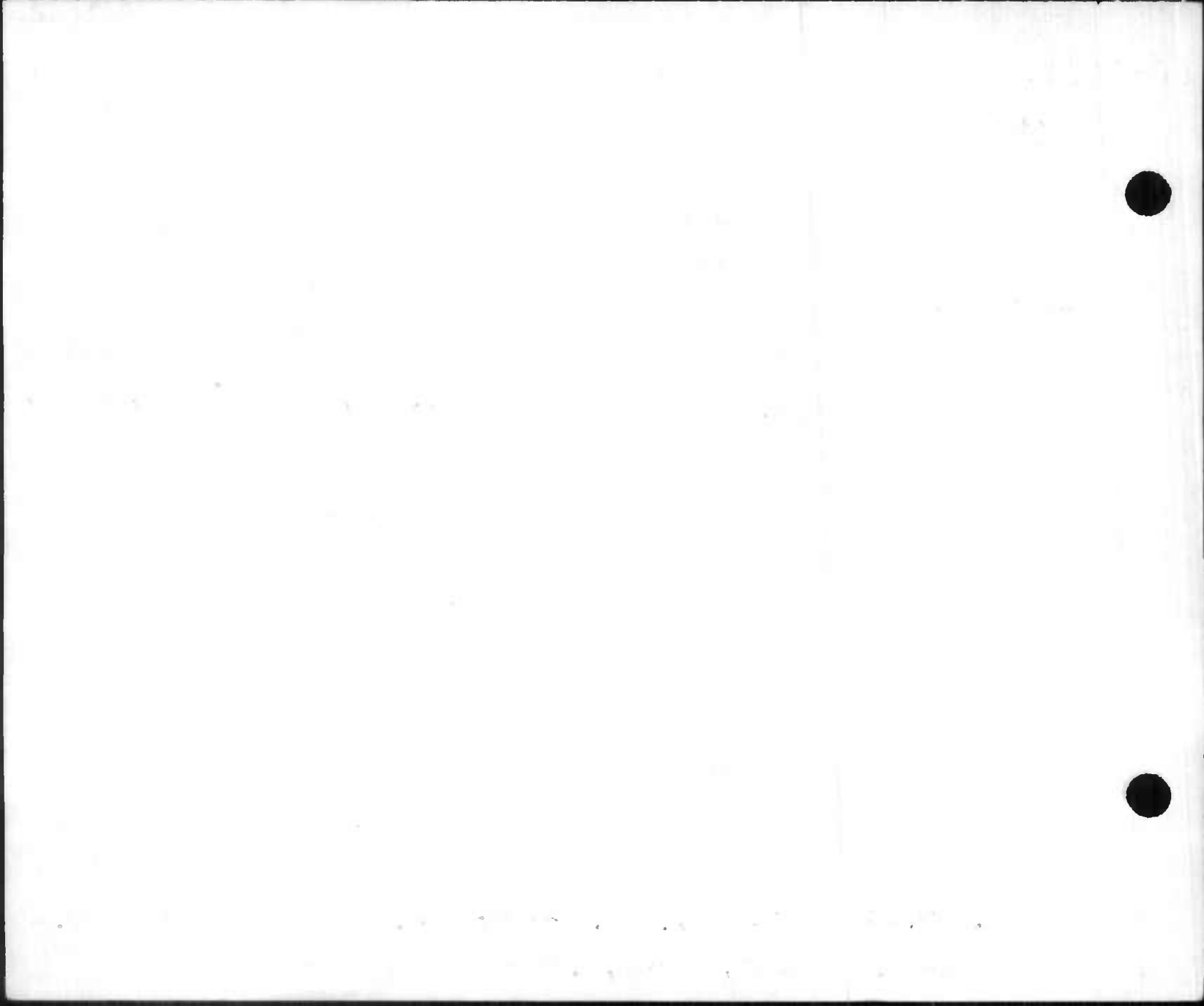
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10691

|                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                    |                                                                                                                                                             |                                                                                                |                                                                               |                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    | 2a DATE OF DEATH                                                                                                                                            |                                                                                                | 2b HOUR                                                                       |                                                  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Robert Wayne Freel                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    | 4 18 86                                                                                                                                                     |                                                                                                | 1245 PM                                                                       |                                                  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br>White                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 23 33                                                                                                               |                                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.                                    |                                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Iowa                                                                                                                                                                                                                                                                                                                                              | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                     |                                                  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Wyman Park Health System |                                                                                                                                                             | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Instructor                     |                                                                               | 12b KIND OF BUSINESS OR INDUSTRY<br>Trade School |
| 13a STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                               | 13b COUNTY<br>Harford                                                                                                              | 13c CITY OR TOWN<br>Edgewood                                                                                                                                | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                               |                                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Roy Freel                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ethel Mae Crispin                                                                                          |                                                                                                |                                                                               |                                                  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                       |                                                                                                                                    | 16b SOCIAL SECURITY NO.<br>Army retired 1973 478-34-3                                                                                                       |                                                                                                | 17 INFORMANT<br>ADDRESS<br>Md. 21040                                          |                                                  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) hemorrhage into lung<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) progressive adenocarcinoma of lung eroding into artery<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                    | 17b Ruth E. Freel, 1107 Hanson Road, Edgewood, Md. 21040                                                                                                    |                                                                                                |                                                                               |                                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>metastatic disease, history of cigarette abuse                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                             |                                                                                                |                                                                               |                                                  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                    | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                             |                                                                                                | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                                  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                              |                                                                                                                                    | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                   |                                                                                                | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                      |                                                                                                                                    | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                          |                                                                                                | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                  |
| 22a I certify that (I) (this hospital) attended the deceased from 4/17, 1986, to 4/18, 1986, that (I) (we) last saw the deceased alive on 4/18/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (did not) view the body after death.                                                                                         |                                                                                                                                    |                                                                                                                                                             |                                                                                                |                                                                               |                                                  |
| 22b SIGNATURE<br>Scott Touger                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                    | DEGREE<br>MD                                                                                                                                                |                                                                                                | 22c DATE SIGNED<br>4/18/86                                                    |                                                  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Scott Touger, MD                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                    | 22e ADDRESS<br>3100 Wyman Park Dr Baltimore                                                                                                                 |                                                                                                |                                                                               |                                                  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                    | 23b DATE<br>April 22, 1986                                                                                                                                  |                                                                                                | 23c NAME OF CEMETERY OR CREMATORY<br>Vet. Cem. Md.                            |                                                  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Howard K. McComas III, Abingdon, Md. 21009                                                                                                                                                                                                                                                                                                                     |                                                                                                                                    | 23d LOCATION<br>CITY OR TOWN<br>Owings Mills Balto Md.                                                                                                      |                                                                                                | 25a DATE REC'D. BY REGISTRAR<br>APR 21 1986                                   |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                    | 25b REGISTRAR'S SIGNATURE<br>John Davidson                                                                                                                  |                                                                                                |                                                                               |                                                  |



0-02838

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10692  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                    |                                                                                                                                                             |                                                                                      |                                                                                                       |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RUBY FREELAND</b>                                                                                                                                                                                                                                                                                                  |                                                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/7/86</b>                                 |                                                                                                       | 2b. HOUR<br><b>7<sup>50</sup> A.M.</b>                                                                                     |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>BLACK</b>                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 24 05</b>                                                                                                        |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b><br>YRS. MONTHS DAYS HOURS MIN.                           |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                     |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Principal</b> |                                                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>                                                                         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                             |                                                                                                                                    |                                                                                                                                                             | 13b. COUNTY                                                                          | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George West</b>                                                                                                                                                                                                                                                                                              |                                                                                                                                    |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy M. Harris</b>              |                                                                                                       |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                         |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br><b>214-40-4200</b>                                                                                                              |                                                                                      | 17. INFORMANT<br><b>Ruby Griffin</b><br>ADDRESS<br><b>2206 Roslyn Avenue<br/>Baltimore, Md. 21216</b> |                                                                                                                            |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |                                                                                                                                    |                                                                                                                                                             |                                                                                      |                                                                                                       |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>POOR NUTRITIONAL STATUS, ANEMIA</b>                                                                                                                                                                            |                                                                                                                                    |                                                                                                                                                             |                                                                                      |                                                                                                       |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                            |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                     |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/25/86</b> to <b>3/27/86</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                       |                                                                                                                                    |                                                                                                                                                             |                                                                                      |                                                                                                       |                                                                                                                            |
| 22b. SIGNATURE<br><b>Kenneth L. Shapiro</b>                                                                                                                                                                                                                                                                                                               |                                                                                                                                    | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                      | 22c. DATE SIGNED<br><b>4/7/86</b>                                                                     |                                                                                                                            |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kenneth L. Shapiro</b>                                                                                                                                                                                                                                                                                        |                                                                                                                                    | 22e. ADDRESS<br><b>2929 Guilford Ave Balt. Md. 21218</b>                                                                                                    |                                                                                      |                                                                                                       |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>Burial</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                    | 23b. DATE<br><b>4-11-1986</b>                                                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>                   |                                                                                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                         |
| 24. FUNERAL DIRECTOR<br>NAME: <b>Sons Funeral Home, Inc.</b><br>ADDRESS: <b>2501 Gwynns Falls Pkwy Baltimore, Md.</b>                                                                                                                                                                                                                                     |                                                                                                                                    |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 08 1986</b>                                  |                                                                                                       | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson Anderson</b>                                                                |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

0-03833

20X COLLECTION



00-05659

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

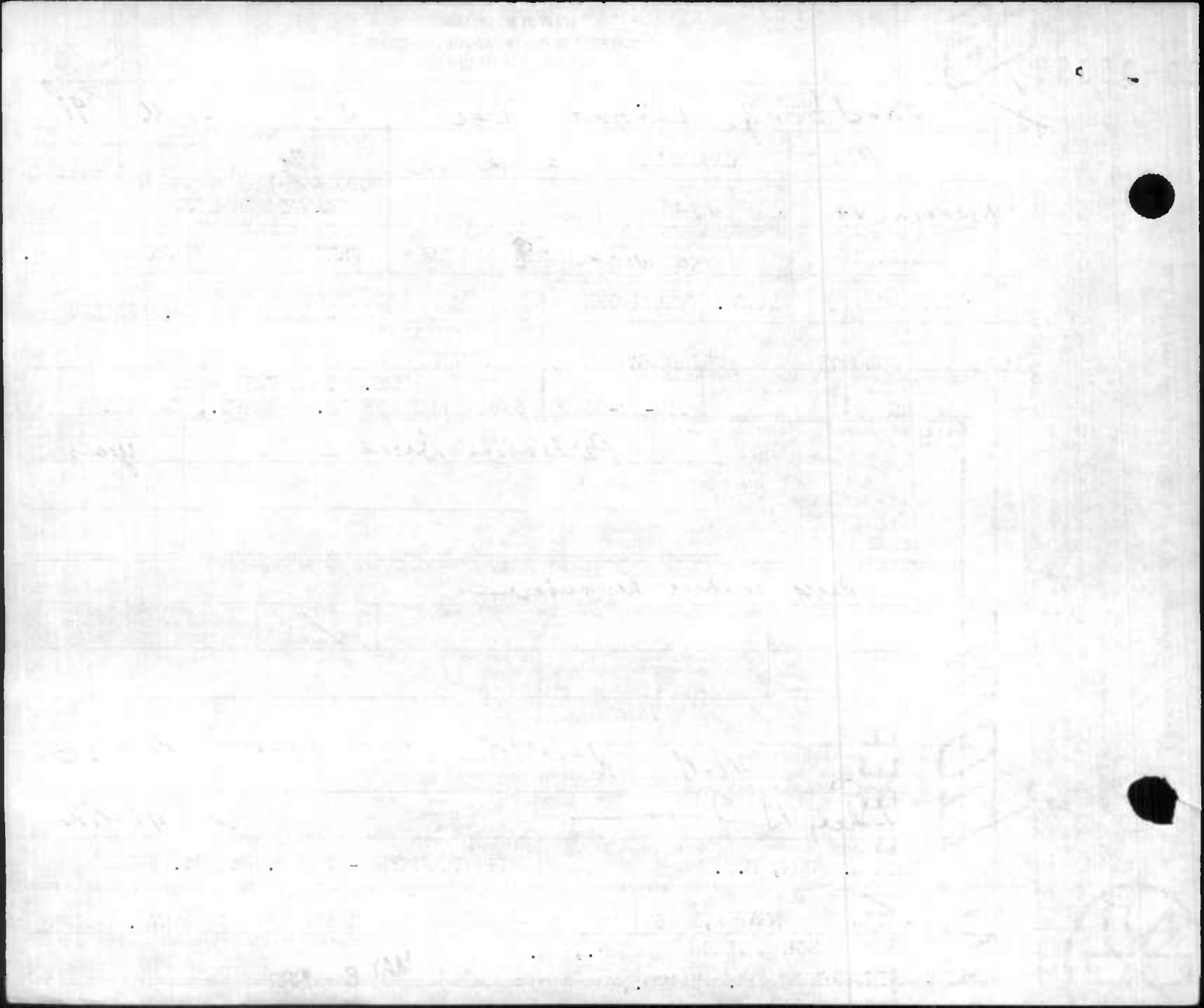
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 10693

|                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                          |                                                                                                                                                          |                                                                                                                            |                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Friedberg, Herbert Lee</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 - 28 86</b>                                                                                                  |                                                                                                                            | 2b. HOUR<br><b>9P</b> M                                                    |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br><b>CAUCASIAN</b>                                                                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 22 12</b>                                                                                                     |                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORFOLK, VA</b>                                                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.          |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KESWICK NURSING HOME</b> |                                                                                                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PRESIDENT</b>                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SHELburne CO.</b>                  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTIMORE</b>                                                                                                                                                                                                                                       |                                                                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>XX</b>                                                | 13e. STREET ADDRESS / ZIP CODE<br><b>3502 SHELburne RD. #21208</b>                                                         |                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SOLOMON FRIEDBERG</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JENNIE GRAF</b>                                                                                      |                                                                                                                            |                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br><b>216-10-6600</b>                                                                                           | 17. INFORMANT<br>ADDRESS<br><b>MRS. MINNA FRIEDBERG 3502 SHELburne RD. BALTO., MD 21208</b>                                                              |                                                                                                                            |                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Parkinsons Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b> |                                                                                                                                          |                                                                                                                                                          |                                                                                                                            |                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Right cerebral hemorrhage</b>                                                                                                                                                                                                                                                     |                                                                                                                                          |                                                                                                                                                          |                                                                                                                            |                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                                                                            |                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |                                                                                                                            |                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/23/85</b> , 19 <b>85</b> , to <b>4/28</b> , 19 <b>86</b> , that (I) (we) (we last saw the deceased alive on <b>4/28</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                               |                                                                                                                                          |                                                                                                                                                          |                                                                                                                            |                                                                            |
| 22b. SIGNATURE<br><b>Phil L. Noon</b>                                                                                                                                                                                                                                                                                                                                                                                    | DEGREE<br><b>PHIL L. NOON, M.D.</b>                                                                                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               | 22c. DATE SIGNED<br><b>4/28/86</b>                                                                                         |                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                          | 22e. ADDRESS                                                                                                                                             |                                                                                                                            |                                                                            |
| <b>PHIL L. NOON, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                          | <b>KESWICK HOME - 700 W. 40th St. #21211</b>                                                                                                             |                                                                                                                            |                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                               | 23b. DATE<br><b>MAY 1, 1986</b>                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>REISTERSTOWN BALTO. MD</b>                                                |                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 6 1986</b>                                                                                                       | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                                                                         |                                                                            |
| <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                          |                                                                                                                                                          |                                                                                                                            |                                                                            |

BP



00-04117

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please replace over container. Pages 4 and 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be called on.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO. 10694

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Paul Lee Friedel</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4/13/86</b> TIME<br><b>7:18 AM</b>                                                                                   |  |                                                                                                                         |  |
| 3. SEX<br><b>m</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>Cauc.</b>                                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>0-3-28-34</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b>                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Handyman</b>                                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13a. COUNTY <b>Baltimore</b>                                                                                                                                                                                                                                                             |  | 13c. CITY OR TOWN<br><b>Owings Mills</b>                                                                                                |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                |  | 13e. STREET ADDRESS / ZIP CODE<br><b>P.O. Box 101 / 21117</b>                                                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Adolph Friedel</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Eva Gaigley</b>                                                                                            |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>                                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO<br><b>216-50-2786</b>                                                                                           |  | 17. INFORMANT NAME ADDRESS<br><b>Mary Webb 12002 Bonita Ave. Owings Mills Md.</b>                                                                           |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>sepsis (Klebsiella)</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>error CEC 4/13/86</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>6 days</b> |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>S/P cadaveric renal transplant; CMV Hepatitis + hepatic encephalopathy, DIC.</b>                                                                                                                                                                                   |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION<br><b>4 mo ago - different admission</b>                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>End stage Renal disease</b>                                                      |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>19</b>                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M.</b>                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 13, 1986</b> , to <b>Apr. 13, 1986</b> , that (I) (we) last saw the deceased alive on <b>April 13, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                            |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>Carol E Copeland MD</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |  | DEGREE<br><b>MD</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>4/13/86</b>                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carol E Copeland</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  | 22e. ADDRESS<br><b>Univ. of Md Hospital 22 S. Greene St Baltimore 21201</b>                                                                                 |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>Apr. 16, 1986</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAKLAND Cem.</b>                                                                                                   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll Md.</b>                                                |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Ed Schmitt</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 18 1986</b>                                                                                                         |  |                                                                                                                         |  |
| ADDRESS<br><b>Owings Mills, Md 21117</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                            |  |                                                                                                                         |  |

BP

1000 ft

1000 ft

1000 ft

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1000 ft

1000 ft

1000 ft

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10695  
REG. NO.1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                       |                                                                                                                                                             |                                                                                                 |                                                                           |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Samuel J Frier, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                       |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 14 86</b>                                           |                                                                           | 2b. HOUR<br><b>9:05 PM</b>                                                                                                 |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br><b>black</b>                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 4 34</b>                                                                                                         |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>51</b>          |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md</b>                                                                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>          |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housing Inspector</b>    |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balti City Dept of Housing</b>                                                     |
| 13a. STATE<br><b>md</b>                                                                                                                                                                                                                                                                                                                                                                                                       | 13b. COUNTY                                                                                                                           | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3604 Liberty Heights 21215</b>       |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Frier</b>                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pearl Handy</b>                                                                                         |                                                                                                 |                                                                           |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-30-6855</b>                                                         | 17. INFORMANT ADDRESS<br><b>Pearl Simins 1402 Ward Street</b>                                                                                               |                                                                                                 |                                                                           |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Massive Pulmonary Embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Prob. Massive Myocardial Infarction</b> |                                                                                                                                       |                                                                                                                                                             |                                                                                                 |                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CVA</b>                                                                                                                                                                                                                                                                                   |                                                                                                                                       |                                                                                                                                                             |                                                                                                 |                                                                           |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                      |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                                                                           |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                           |                                                                                                                            |
| 22a. I certify that (I) (has/have) attended the deceased from <b>4-14</b> , 19 <b>86</b> , to <b>4-14</b> , 19 <b>86</b> , that (I) (have) lost<br>saw the deceased alive on <b>4-14</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (do not) view the body after death.                                                          |                                                                                                                                       |                                                                                                                                                             |                                                                                                 |                                                                           |                                                                                                                            |
| 22b. SIGNATURE<br><b>Rosita R. Cruz M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                       |                                                                                                                                                             |                                                                                                 | 22c. DATE SIGNED<br><b>4-14-86</b>                                        |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rosita R. Cruz M.D.</b>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                       |                                                                                                                                                             |                                                                                                 | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>                                  |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                 | 23b. DATE<br><b>4/18/86</b>                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Vet</b>                                                                                            |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills md</b>      |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William C. March F.H. West 4300 Wabash Ave</b>                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                       |                                                                                                                                                             |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR                                             | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                                                 |

27700-00

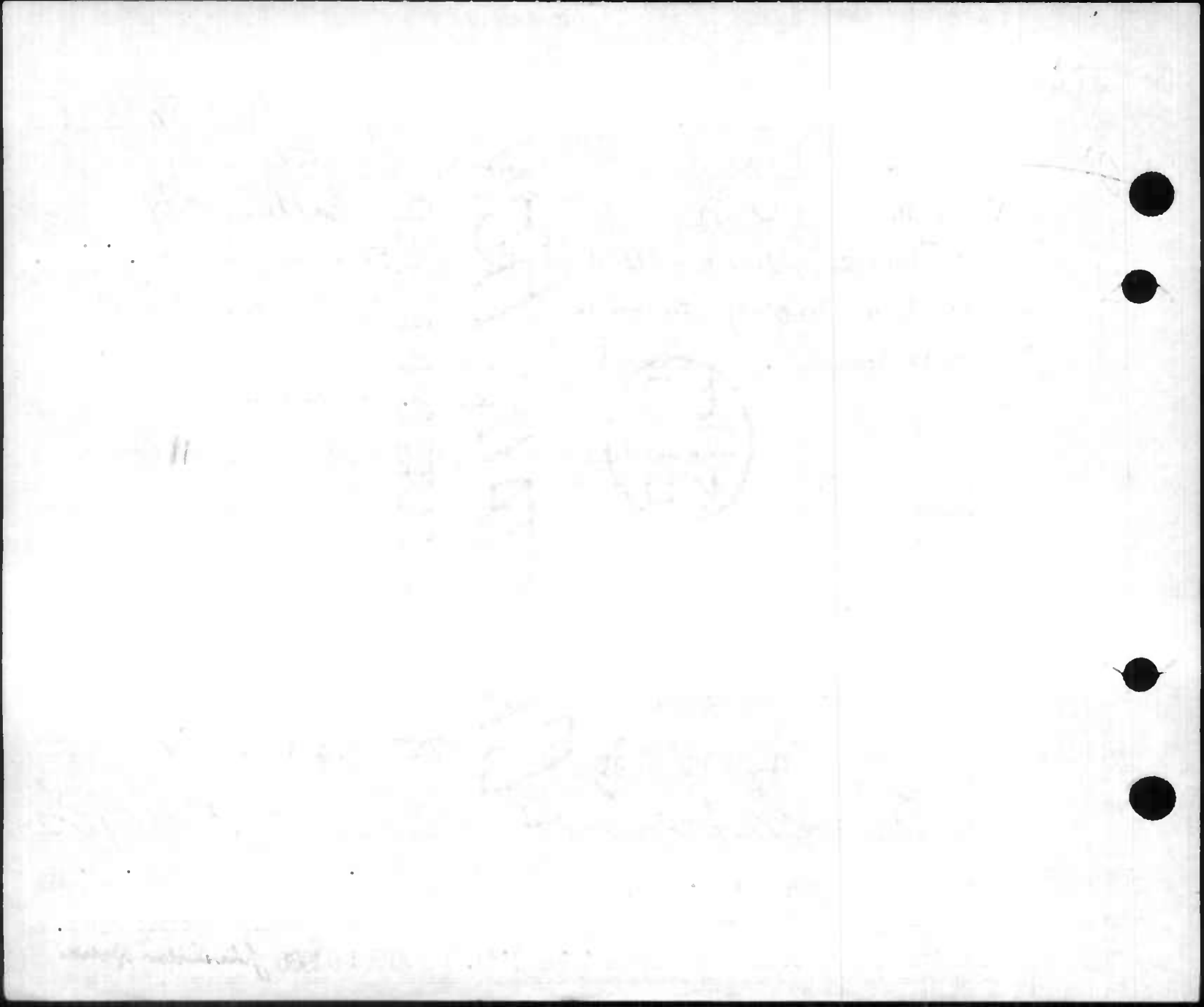


0-03788

Film G614 item 12b, 15, 16a, 16b

1- FOR  
STATE 4/22/86 rja  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10696  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |                                               |                                                                                     |                                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>REED E. FRIEND                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>4 13 86 |                                                                                     | 2b HOUR<br>3:30 P.M.                                         |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br>White                                                                                                                 |                                               | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>7 10 31                                        |                                                              |  |
| 6 AGE<br>54 YRS.                                                                                                                                                                                                                                                                                                                                                                    |  | 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Cecilville                                                                       |                                               | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                  |                                                              |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                          |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                       |                                               |                                                                                     |                                                              |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                               |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ of Maryland Hosp. |                                               | 12a USUAL OCCUPATION<br>(STATE OF WORK FOR MOST OF WORKING LIFE)<br>Economist       |                                                              |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br>U.S. Dept. of Agr.                                                                                                                                                                                                                                                                                                                              |  | 13a STATE<br>Maryland                                                                                                           |                                               | 13b COUNTY<br>Baltimore                                                             |                                                              |  |
| 13c CITY OR TOWN<br>Baltimore                                                                                                                                                                                                                                                                                                                                                       |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |                                               | 13e STREET ADDRESS, ZIP CODE<br>Dowling Drive 208d                                  |                                                              |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Stanley R. Friend                                                                                                                                                                                                                                                                                                                          |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Edna FRANTZ France                                                                   |                                               |                                                                                     |                                                              |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                          |  | 16b SOCIAL SECURITY NO.<br>Korean Conflict 220-28-9456                                                                          |                                               | 17 INFORMANT<br>ADDRESS<br>Alice S. Friend-wife-(same as 13e)                       |                                                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Non-Hodgkin's Lymphoma                                                                                                                                                                                                                                |  |                                                                                                                                 |                                               |                                                                                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>11 Months |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |                                               |                                                                                     |                                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |                                               |                                                                                     |                                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.                                                                                                                                                                                                                                                    |  |                                                                                                                                 |                                               |                                                                                     |                                                              |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |                                               | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                              |  |
| 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                        |  |                                                                                                                                 |                                               |                                                                                     |                                                              |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |                                               | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)      |                                                              |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                            |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |                                               | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>April 13</u> , 19 <u>86</u> , to <u>April 13</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>April 13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                 |                                               |                                                                                     |                                                              |  |
| 22b PHYSICIAN'S NAME (TYPE OR PRINT)<br>Russell DeLuca, MD.                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                 |                                               | 22c ADDRESS<br>University of Md. Hospital Balt. Md.                                 |                                                              |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                               |  | 23b DATE<br>4-18-1986                                                                                                           |                                               | 23c NAME OF CEMETERY OR CREMATORY<br>Blooming Rose Cemetery                         |                                                              |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Friendsville Garrett Md.                                                                                                                                                                                                                                                                                                               |  | 24 FUNERAL DIRECTOR<br>Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md.                                           |                                               |                                                                                     |                                                              |  |
| 25a DATE REC'D. BY REGISTRAR<br>APR 16 1986                                                                                                                                                                                                                                                                                                                                         |  | 25b REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                                                             |                                               |                                                                                     |                                                              |  |





00-03744

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8610691

|                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                           |                                                                     | 2b. HOUR                                                                       |                                              |
| DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | MONTH DAY YEAR                                                                                                                                              |                                                                     | IF UNDER 24 HRS.                                                               |                                              |
| RICHARD Wilson FRITTER                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | APRIL 11, 1986                                                                                                                                              |                                                                     | 6:45 A.M.                                                                      |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                            |                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)                                                |                                              |
| MALE                                                                                                                                                                                                                                                                                                                                                                   | WHITE                                                                                                  | MONTH DAY YEAR<br>11 16 37                                                                                                                                  |                                                                     | 48 YRS.                                                                        |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                              |
| MD                                                                                                                                                                                                                                                                                                                                                                     | U.S.A.                                                                                                 |                                                                                                                                                             |                                                                     | BALTIMORE CITY MD.                                                             |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY            |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                              | JOHNS HOPKINS HOSPITAL                                                                                 |                                                                                                                                                             | Program Analyst                                                     |                                                                                | APC                                          |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                             | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                           | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                                                            |                                              |
| MD                                                                                                                                                                                                                                                                                                                                                                     | Cecil                                                                                                  | Rising Sun                                                                                                                                                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 19 Sunrise Dr. 21911                                                           |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |                                                                     |                                                                                |                                              |
| FIRST MIDDLE LAST<br>Wilson Marshall Fritter                                                                                                                                                                                                                                                                                                                           |                                                                                                        | FIRST MIDDLE LAST<br>Margaret Evelyn Howell                                                                                                                 |                                                                     |                                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                      |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                                                                     | 17. INFORMANT ADDRESS                                                          |                                              |
| NO                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 215-34-7109                                                                                                                                                 |                                                                     | Betty B. Fritter (SAME AS 13)                                                  |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest.</u>                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                | 4/11/86                                      |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                | 4/86                                         |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                | 12/85                                        |
| (b) <u>sepsis</u>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                |                                              |
| (c) <u>aggravation of eosinophilic leukemia</u>                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>eosinophilic leukemia.</u>                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                             |                                                                     |                                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                     | 20a. AUTOPSY?                                                                  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                             |                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                        |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                 |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |                                                                     | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                              |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>April 10</u> , 19 <u>86</u> , to <u>April 11</u> , 19 <u>86</u> , that (1) (we) lost the deceased alive on <u>4/11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |                                                                                                        | 22b. SIGNATURE                                                                                                                                              |                                                                     | 22c. DATE SIGNED                                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        | Brenda W. Cooper MD                                                                                                                                         |                                                                     | 4/11/86                                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 22e. ADDRESS                                                                                                                                                |                                                                     |                                                                                |                                              |
| Brenda W. Cooper, MD                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | 600 N. WOLFE ST.<br>Johns Hopkins Hospital, Baltimore, MD 21205                                                                                             |                                                                     |                                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                              | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                                                                                |                                              |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                 | 4/14/86                                                                                                | WEST NOTTINGHAM                                                                                                                                             | Columbia Cecil                                                      |                                                                                |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |                                                                     | 25b. REGISTRAR'S SIGNATURE                                                     |                                              |
| Richard L. Goodie, Rising Sun, MD                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | APR 16 1986                                                                                                                                                 |                                                                     |                                                                                |                                              |

00-00000

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

DATE 11-10-00 BY SP-10

00-03796

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10698

1- FOR  
STATE  
REGISTRAR

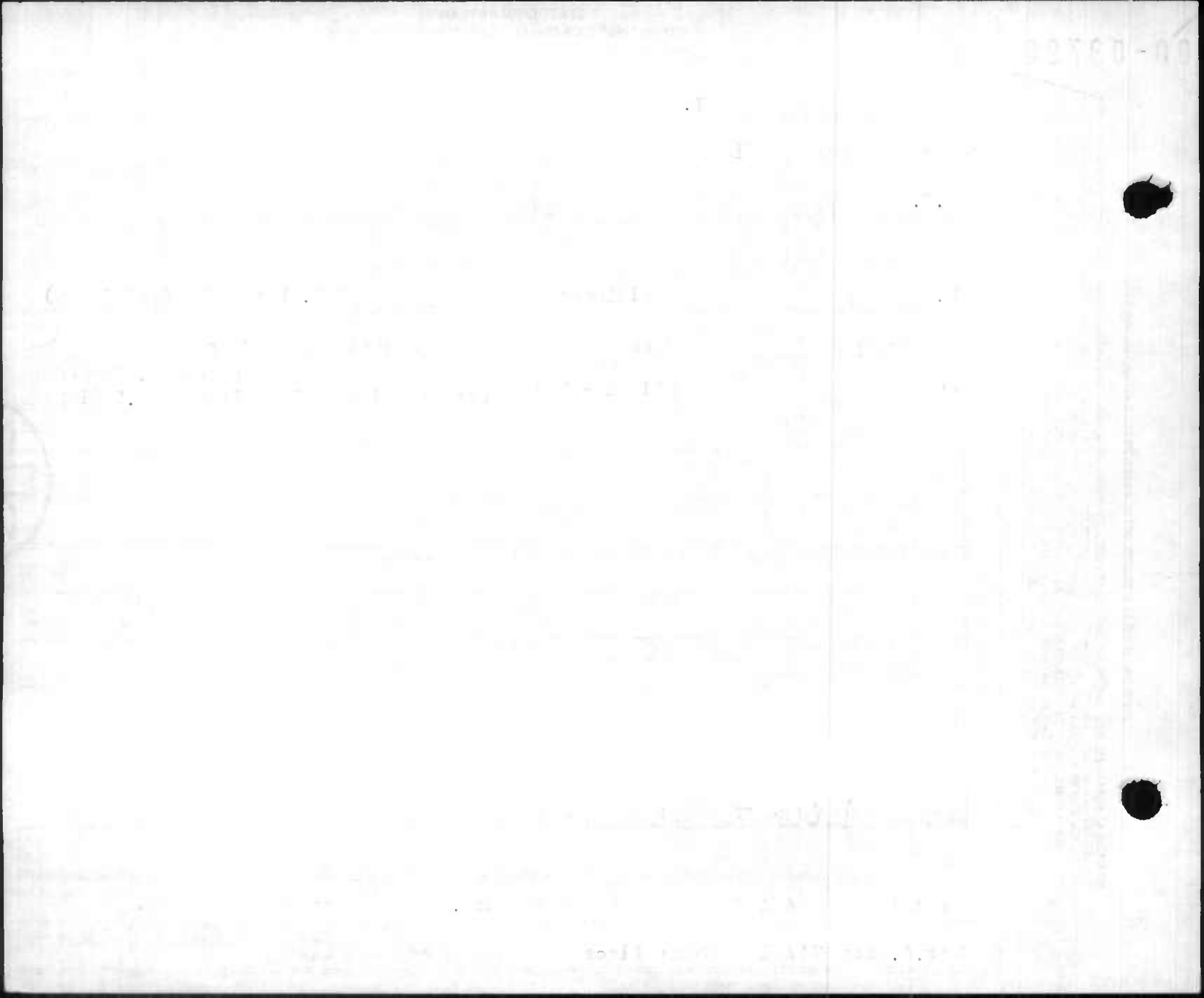
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                            |  |                                                                               |  |                                                                     |  |                                      |  |                                |  |                                                                                     |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------------------|--|--------------------------------|--|-------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |         | FIRST                                                                                                      |  | MIDDLE                                                                        |  | LAST                                                                |  | 2a. DATE KNOWN OF<br>DEATH MATED     |  | MONTH DAY YEAR                 |  | 2b. HOUR                                                                            |                                                 |
| NELLIE                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | I.                                                                                                         |  | FROST                                                                         |  |                                                                     |  | <input checked="" type="checkbox"/>  |  | 4-13-86                        |  | M                                                                                   |                                                 |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE | 5. DATE OF BIRTH                                                                                           |  | 6. AGE (IN YEARS)                                                             |  | IF UNDER 1 YR.                                                      |  | IF UNDER 24 HRS.                     |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | 7d. HOUR                                                                            |                                                 |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                   | Black   | 9/10/98                                                                                                    |  | 87 YRS.                                                                       |  | MONTHS DAYS HOURS MIN.                                              |  |                                      |  | 4-13-86                        |  | 12:38                                                                               |                                                 |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                             |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |  | 8. MARRIED                                                                    |  | NEVER MARRIED                                                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                |  |                                                                                     |                                                 |
| N.C.                                                                                                                                                                                                                                                                                                                                                                                                                                     |         | USA                                                                                                        |  | <input type="checkbox"/> WIDOWED                                              |  | <input type="checkbox"/> NEVER MARRIED                              |  | Baltimore City                       |  |                                |  |                                                                                     |                                                 |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)              |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                                      |  |                                |  |                                                                                     |                                                 |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                |         | 833 W. Pratt Street APT. 502                                                                               |  |                                                                               |  |                                                                     |  |                                      |  |                                |  |                                                                                     |                                                 |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                               |         | 13b. COUNTY                                                                                                |  | 13c. CITY OR TOWN                                                             |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                  |  |                                |  |                                                                                     |                                                 |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                            |  | Baltimore                                                                     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 833 W. Pratt ST, Apt 502 (01)        |  |                                |  |                                                                                     |                                                 |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |         | MIDDLE                                                                                                     |  | LAST                                                                          |  | 15. MOTHER'S MAIDEN NAME                                            |  | MIDDLE                               |  | LAST                           |  |                                                                                     |                                                 |
| Berry                                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                                                            |  | Frost                                                                         |  | Rachel                                                              |  |                                      |  | Frost                          |  |                                                                                     |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                    |         | 16b. SOCIAL SECURITY NO.                                                                                   |  | 17. INFORMANT                                                                 |  | ADDRESS                                                             |  |                                      |  |                                |  |                                                                                     |                                                 |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                       |         | 218-14-9260                                                                                                |  | Joanna Wilson                                                                 |  | 43 Monroe St. Inwood<br>Long Island, N.Y 11696                      |  |                                      |  |                                |  |                                                                                     |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                            |         |                                                                                                            |  |                                                                               |  |                                                                     |  |                                      |  |                                |  |                                                                                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                      |         |                                                                                                            |  |                                                                               |  |                                                                     |  |                                      |  |                                |  |                                                                                     |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                          |  |                                                                               |  |                                                                     |  |                                      |  |                                |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                 |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                     |  |                                      |  |                                |  |                                                                                     |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                             |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                             |  | 21f. LOCATION<br>STREET                                                       |  | CITY OR TOWN                                                        |  | COUNTY                               |  | STATE                          |  |                                                                                     |                                                 |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                                                                                                            |  |                                                                               |  |                                                                     |  |                                      |  |                                |  |                                                                                     |                                                 |
| ACTUAL<br>SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                      |         | TITLE (SPECIFY)                                                                                            |  | DATE                                                                          |  | SIGNED                                                              |  |                                      |  |                                |  |                                                                                     |                                                 |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                |         | Assistant                                                                                                  |  | 4-14-86                                                                       |  |                                                                     |  |                                      |  |                                |  |                                                                                     |                                                 |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |         | ADDRESS                                                                                                    |  |                                                                               |  |                                                                     |  |                                      |  |                                |  |                                                                                     |                                                 |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                |         | 111 Penn Street                                                                                            |  |                                                                               |  |                                                                     |  |                                      |  |                                |  |                                                                                     |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                             |         | 23b. DATE                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                               |  | STATE                          |  |                                                                                     |                                                 |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | 4/17/86                                                                                                    |  | Mt Auburn Cem.                                                                |  | Westport                                                            |  | Md.                                  |  |                                |  |                                                                                     |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                             |         | ADDRESS                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR                                                 |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                                      |  |                                |  |                                                                                     |                                                 |
| Chas. A. Rice FSPA                                                                                                                                                                                                                                                                                                                                                                                                                       |         | 1300 Eutaw Place                                                                                           |  | APR 16 1986                                                                   |  | John Davidson-Randall                                               |  |                                      |  |                                |  |                                                                                     |                                                 |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))



00-05910

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

10699

|                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  |                                                                                                                                               |  |                                                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Myrtle M. Fry</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4 20 86</b> 2b. HOUR<br><b>10:22 P.M.</b>                                                              |  |                                                                                                                                 |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>Cauc.</b>                                                                                                                           |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 28 15</b>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTH DAY YEAR<br><b>70</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>B. City</b> (MD)                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hospital</b> |  |                                                                                                                                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unk.</b>                                                    |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br><b>City</b>                                                                                                                        |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                         |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William</b>                                                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Laura</b>                                                                                        |  | 16. STREET ADDRESS / ZIP CODE<br><b>1743 Bert St 21230</b>                                                                                    |  |                                                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>21648114F</b>                                                                                                      |  | 17. INFORMANT<br><b>William Triple</b>                                                                                                        |  | ADDRESS<br><b>Same</b>                                                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Respiratory Failure</b> |  |                                                                                                                                                   |  |                                                                                                                                               |  |                                                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Recurrent Pneumonia, Sepsis</b>                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  |                                                                                                                                               |  |                                                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                |  |                                                                                                                                 |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><b>STREET</b>                                                                                      |  |                                                                                                                                 |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>3-30</b> , 19 <b>86</b> , to <b>4-30</b> , 19 <b>86</b> that (1) (we) last saw the deceased alive on <b>4-30</b> , 19 <b>86</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) was (did) (did not) view the body after death.                                             |  |                                                                                                                                                   |  |                                                                                                                                               |  |                                                                                                                                 |  |
| 22b. SIGNATURE<br><b>Mitchell Jelen</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                   |  | DEGREE<br><b>M.D.</b>                                                                                                                         |  | 22c. DATE SIGNED<br><b>4-30-86</b>                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mitchell Jelen</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |  | 22e. ADDRESS<br><b>3001 S. Hanover St Baltimore, MD 21230</b>                                                                                 |  |                                                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>5-4-86</b>                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brookview Cemetery</b>                                                                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Rising Sun Cecil MD</b>                                                           |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Richard L. Goodie</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 7 1986</b>                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Madison Randle</b>                                                                        |  |

BP

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00-05731

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10700

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mary Fuhrman</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 26, 1986</b>           |                                                                                                                                                             |  | 2b. HOUR<br><b>2:00PM</b>                                                                       |  |                                                                                                                            |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>White</b>                                                                                                                       |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 28 07</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78 yrs</b> YRS.                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>/ Baltimore City MD.</b>                             |  |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                        |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Food Stand</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Stadium</b>                                                                        |                                              |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br><b>Balto.,</b>                                                                                                                 |                                                                        | 13c. CITY OR TOWN<br><b>Balto.,</b>                                                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>706 N. Charles Street Balto., 21202</b>                                               |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anthony Rollinitis</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Mutasavag</b> |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>217-05-6102</b>                                                                                                |                                                                        | 17. INFORMANT<br>ADDRESS<br><b>Medical Records Department 21201<br/>Maryland General Hospital Linden Ave.</b>                                               |  |                                                                                                 |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br><b>888</b> IMMEDIATE CAUSE (a) <b>Brain Death</b> Acute Subdural Hematoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Acute right subdural hematoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Stroke</b> |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Coronary artery disease; Ventricular tachycardia; facial fracture</b>                                                                                                                                                                                                             |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION<br><b>April 22, 1986</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Subdural hematoma</b>                                                                  |                                                                        |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOURS MONTH DAY YEAR<br><b>6 P.M. 4/21/86 19</b>                                                                       |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Information available subject fell</b>                                 |  |                                                                                                 |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Madison &amp; Charles St.s</b>                                   |                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                                                                     |  |                                                                                                 |  |                                                                                                                            |                                              |
| 22a. I certify that (x) (this hospital) attended the deceased from <b>April 21 19 86</b> to <b>April 26 19 86</b> that (x) (we) lost saw the deceased alive on <b>April 26 19 86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (y) (we) (did) (not) view the body after death.                                                                                  |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>James L. Fitzpatrick, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |                                                                        | DEGREE<br>CERTIFYING MEDICAL EXAMINER<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>4/26/86</b>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James L. Fitzpatrick, M.D.</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |                                                                        | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                        |  |                                                                                                 |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>4-28-86</b>                                                                                                                   |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               |                                                                        | ADDRESS<br><b>Balto., Md.</b>                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 05 1986</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodriguez</b>                                                              |                                              |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10750-01





00-03367

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10701  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |                                                |                                                                                                                                                             |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DAVENPORT J. FULTZ                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 10 86 |                                                                                                                                                             |  | 2b. HOUR<br>12:15pm                                                                                                        |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>White                                                                                                                                |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 9, 1912                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                          |                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital, Baltimore City |                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic                                                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MTA                                                                                   |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br>Baltimore                                                                                                                        |                                                | 13c. CITY OR TOWN<br>Arbutus                                                                                                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Grover Fultz                                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nettie Hutchens                                                                                |                                                | 13e. STREET ADDRESS / ZIP CODE<br>4729 Gateway Ter. 21227                                                                                                   |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>n/a/                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-03-9072                                                                          |                                                | 17. INFORMANT<br>ADDRESS<br>Gertrude Fultz 4729 Gateway Ter. 21227                                                                                          |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARCINOMA OF THE LARYNX</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                 |                                                |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |                                                |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                      |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 4</u> 19 <u>86</u> to <u>APRIL 10</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>APRIL 10</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |                                                                                                                                                 |                                                |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Oscar Mendez M.D.</u>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                 |                                                | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>10 APRIL '86                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OSCAR C. MENDEZ                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 |                                                | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>4/14/86                                                                                                                            |                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Md.                                                          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ambrose Inc. 1328 Sulphur Sp. Rd. 21227                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |                                                | 25a. DATE REC'D. BY REGISTRAR<br>APR 11 1986                                                                                                                |  |                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |                                                | 25b. REGISTRAR'S SIGNATURE<br><u>Jana Davidson-Bonfante</u>                                                                                                 |  |                                                                                                                            |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified and an autopsy performed.

0-03381



00-02599

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 10702  
REG. NO.

|                                                                                                                        |                                                                                                                                            |                                                                                                                                                            |                                                                                          |                                                                  |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>ELEANOR M. FULLER</b>                                                            |                                                                                                                                            |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR <b>APRIL 2, 1986</b>                                  |                                                                  | 2b HOUR<br><b>8:05 A.M.</b>                                                                    |
| 3 SEX<br><b>FEMALE</b>                                                                                                 | 4 RACE<br><b>WHITE</b>                                                                                                                     | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT. 1 1913</b>                                                                                                   |                                                                                          | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. C.</b>                                                               | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                          | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |                                                                                                |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK, TRADE, OR ART OF LIVING LIFE)<br><b>HOMEMAKER</b> | 12b KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                     |                                                                                                |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE<br><b>MD.</b> |                                                                                                                                            |                                                                                                                                                            | 13b COUNTY<br><b>-</b>                                                                   | 13c CITY OR TOWN<br><b>BALTIMORE</b>                             | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES HAMLIN</b>                                                           |                                                                                                                                            |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MATTIE UNKNOWN</b>                   |                                                                  |                                                                                                |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                       |                                                                                                                                            | 16b SOCIAL SECURITY NO.<br><b>220-18-2626</b>                                                                                                              |                                                                                          | 17 INFORMANT<br>ADDRESS<br><b>WM. FULLER (SON) SAME ADDRESS</b>  |                                                                                                |

|                                                                                                                                                         |  |                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Klebsiella sepsis</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 days</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic infection</b>                                                                                          |  | <b>3 months</b>                                                  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>malnutrition</b>                                                                                               |  | <b>4 months</b>                                                  |

|                                                                                                                                                                                                                                                                                                                                                                |                                                                       |                                                                                                                                                      |                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>respiratory failure as a result of chronic pulmonary disease</b>                                                                                                                                                            |                                                                       |                                                                                                                                                      |                                                                                                                              |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)                                                                         |                                                                                                                              |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                    | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                     |                                                                                                                              |
| 22a I certify that (I) (this hospital) attended the deceased from <b>1/5</b> , 19 <b>86</b> , to <b>4/2</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/2</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                       |                                                                                                                                                      |                                                                                                                              |
| 22b SIGNATURE<br><b>Joseph M Molina MD</b>                                                                                                                                                                                                                                                                                                                     |                                                                       | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED<br><b>4-2-86</b>                                                                                             |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph M Molina MD</b>                                                                                                                                                                                                                                                                                              |                                                                       | 22e ADDRESS<br><b>600 N Wolfe St Baltimore MD 21205</b>                                                                                              |                                                                                                                              |

|                                                                            |                           |                                                        |                                                             |
|----------------------------------------------------------------------------|---------------------------|--------------------------------------------------------|-------------------------------------------------------------|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>               | 23b DATE<br><b>4/5/86</b> | 23c NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b> | 23d LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTIMORE MD.</b> |
| 24 FUNERAL DIRECTOR'S NAME<br><b>SCHMUNEK FUNERAL HOME, INC.</b>           |                           | 25a DATE REC'D. BY REGISTRAR<br><b>APR 04 1986</b>     | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>             |
| 24 FUNERAL DIRECTOR'S ADDRESS<br><b>3331 Brehms Lane, Balto. Md. 21213</b> |                           |                                                        |                                                             |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death, and it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and complete page 4, and return it to the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner will be contacted and a post-mortem examination may be required.

00-0220

26 Jp PHO 2  
LIVERMORE

00-04678

FOR item 1, film#G614-  
1- STATE REGISTRAR 4-25-86jlb

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 10703

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                                                                               |                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GLADYS H FUNK</b>                                                                                                                                                                                                                                                                                               |                                                                                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 22, 1986</b>                         |                                                                                                                                               | 2b. HOUR<br><b>5:10a M</b>                                                           |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>White</b>                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 8 1905</b>                                                                                                    |                                                                                      | 6. AGE IN YEARS (LAST BIRTHDAY)<br><b>80</b> YRS                                                                                              |                                                                                      |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                                                                             |                                                                                      |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>                                    |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                     |                                                                                                                                                             | 13b. COUNTY<br><b>---</b>                                                            | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Hammerbacher</b>                                                                                                                                                                                                                                                                                      |                                                                                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Unknown</b>                 |                                                                                                                                               |                                                                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                         |                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>215-12-9729</b>                                                                                                              |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>John H. Funk, Jr. 201 North Branch Rd. 21222</b>                                                               |                                                                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>UROSEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>VENTRICULAR XXXXX ARRRHYTHMIA</b>                                                                                                                                                                                |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                                                                               |                                                                                      |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                          |                                                                                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)                                                               |                                                                                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                              |                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                             |                                                                                      |
| 22a. I certify that (1) this hospital attended the deceased from <b>APRIL 14 19 86</b> to <b>APRIL 22 19 86</b> that (1) was last<br>saw the deceased alive on <b>APRIL 22 19 86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (do) (did not) (after death)                        |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                                                                               |                                                                                      |
| 22b. SIGNATURE<br><i>Gary Krueh</i>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                     | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                      | 22c. DATE SIGNED                                                                                                                              |                                                                                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GARY KRUEH MD</b>                                                                                                                                                                                                                                                                                             |                                                                                                                                     | 22e. ADDRESS<br><b>CHURCH HOSPITAL<br/>100 N. BROADWAY BALTIMORE, MD. 21231</b>                                                                             |                                                                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF<br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                                                                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                             | 23b. DATE<br><b>4/25/86</b>                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                                                                               |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                                            |                                                                                      |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lilly &amp; Zeiler, Inc. 700 S. Conkling St.</b>                                                                                                                                                                                                                                                                       |                                                                                                                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 24 1986</b>                                                                                                         |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>Lilly &amp; Zeiler</i>                                                                                       |                                                                                      |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-03995

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 0 7 0 4

REG. NO.

|                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                             |                                                |                                                                                                                                      |                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EARL R. GAINES                                                                                                                                                                                                                                         |  |                                                                                                                             | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>04 15 86 |                                                                                                                                      | 2b HOUR<br>8 <sup>05</sup> AM |  |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                     |  | 4 RACE<br>BLACK.                                                                                                            |                                                | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>02 12 27                                                                                        |                               |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS                                                                                                                                                                                                                                                                          |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.                                                                             |                                                | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   |                               |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                        |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE City MD.                                                                   |                                                | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Printers                                                             |                               |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                             |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Charles GEN. |                                                | 12b KIND OF BUSINESS OR INDUSTRY<br>Deluxe check                                                                                     |                               |  |
| 13a STATE<br>MD                                                                                                                                                                                                                                                                                                   |  | 13b COUNTY                                                                                                                  |                                                | 13c CITY OR TOWN<br>Baltimore                                                                                                        |                               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter G. Gaines                                                                                                                                                                                                                                                         |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Johanne Bundy                                                               |                                                | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |                               |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                        |  | 16b SOCIAL SECURITY NO.<br>207-12-6196                                                                                      |                                                | 17 INFORMANT<br>Jean E. Gaines                                                                                                       |                               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) ADENOCARCINOMA LUNG with Metastasis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIOSCLEROTIC HEART DISEASE.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) DIABETES MELLITUS             |  | 19a DATE OF OPERATION                                                                                                       |                                                | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |                               |  |
| 19c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                                                                                                                                                                                      |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                         |                                                | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>CHRONIC OBSTRUCTIVE LUNG DISEASE, SEIZURE DISORDER, HYPERTENSION                                                                                                               |  |                                                                                                                             |                                                |                                                                                                                                      |                               |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                            |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                   |                                                | 21c LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                            |                               |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                       |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                       |                                                | 21f LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                            |                               |  |
| 22a I certify that (I) (this hospital) attended the deceased from 03-31-19-86 to 4-15-19-86 that (I) (we) lost<br>saw the deceased alive on 4-15-19-86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death |  |                                                                                                                             |                                                |                                                                                                                                      |                               |  |
| 22b SIGNATURE<br>SUDHIR PATEL                                                                                                                                                                                                                                                                                     |  | DEGREE                                                                                                                      |                                                | 22c DATE SIGNED<br>4-15-86                                                                                                           |                               |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>SUDHIR PATEL                                                                                                                                                                                                                                                              |  | 22e ADDRESS<br>NORTH CHARLES GEN. HOSPITAL                                                                                  |                                                |                                                                                                                                      |                               |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                             |  | 23b DATE<br>4/21/86                                                                                                         |                                                | 23c NAME OF CEMETERY OR CREMATORY<br>Garrison Forest Vet                                                                             |                               |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills, Md.                                                                                                                                                                                                                                                    |  | 24 FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H West                                                                          |                                                | 25a DATE REC'D. BY REGISTRAR<br>APR 18 1986                                                                                          |                               |  |
| 25b REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                         |  |                                                                                                                             |                                                |                                                                                                                                      |                               |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, Pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

